ROCKY MOUNTAIN MEDICAL JOURNAL

Title Registered U. S. Patent Office

Publication Office
835 Republic Building (1612 Tremont Place),
Denver 2, Colorado
Telephone AComa 2-0547

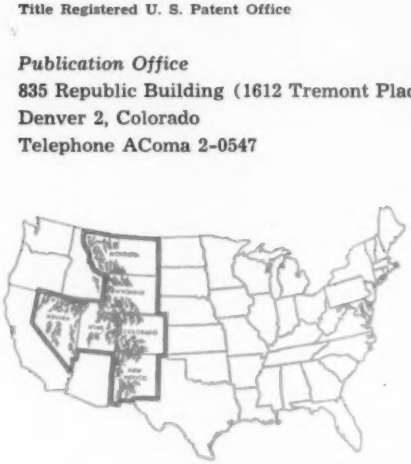


Table of Contents

May 1960, Volume 57, Number 5

Ownership and Sponsorship: The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a non-profit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Rocky Mountain Medical Conference and those medical societies who are represented on the Editorial Board listed above.

Advertising: National representative: The State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Ill.

Subscription: $5.00 per year in advance, postpaid in the United States and its possessions; single copy 50c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

Second-class postage paid at Denver, Colorado.

ROCKY MOUNTAIN MEDICAL JOURNAL

Title Registered U. S. Patent Office

Publication Office
835 Republic Building (1612 Tremont Place),
Denver 2, Colorado
Telephone AComa 2-0547

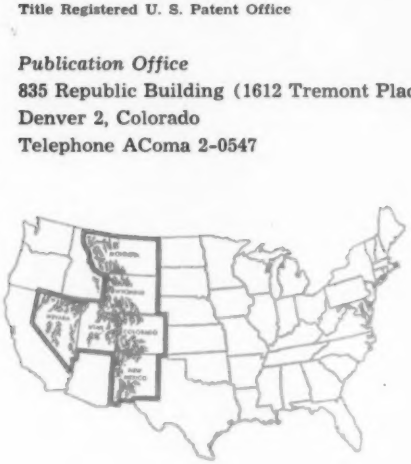


Table of Contents

May 1960, Volume 57, Number 5

Ownership and Sponsorship: The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a non-profit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Rocky Mountain Medical Conference and those medical societies who are represented on the Editorial Board listed above.

Advertising: National representative: The State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Ill.

Subscription: $5.00 per year in advance, postpaid in the United States and its possessions; single copy 50c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

Second-class postage paid at Denver, Colorado.

EDITORIALS

The Golden Platter

In 1955, the Readers' Digest published an article about the family doctor by Paul de Kruif. The author described the family physician of today, his adequate training and postgraduate study. He mentioned that any reader wishing such a family doctor should contact the office of American Academy of General Practice. During three weeks following publication, 70,000 letters arrived at the Academy, requesting lists of such physicians. A similar article followed in the newspapers by Dr. Walter Alvarez. Again the Academy was swamped. The American people obviously want friendly and competent guidance in their medical problems. This has always been true, and the above documentation of the fact was about five years ago.

It must be more true than ever at the present time. Families do not have dollars to throw around, and the price of drugs alone alerts them to the costs of medical care. And they are looking critically at the items on hospital bills. One patient, for example, inquired about a single hypodermic injection for which a charge of $3.50 was made. He was told that it was for postoperative nausea. "Doctor," said he, "I wasn't that nauseated!" Who among us would not see eye to eye with him? And who would not look at the items on a bill of over $150.00 for two nights and a day in the hospital? This is but one minor example of how we and the hospitals are being scrutinized by the public. If the people are not satisfied, and if our profession does not come up with an acceptable answer, the voters are liable to try for something different. What, they will say, have we got to lose?

Congressional manna with the name of Forand, or some other, will be placed before them on a golden platter. They might bite at the well-baited hook. Then there would be a long and expensive trial of inferior medical care—and it would be clear that the gold came out of their own pockets!

*M.D. or TV?**

Nowadays, the doctor is still M.D., but the patient is TV, and says something like this:

"Doc, I need your help. Should I drain all eight sinus cavities and shrink swollen membranes? Or should I take something to get rid of that gray, tired, run-down, ache-all-over feeling? Doc, my problem is I want fast, fast relief, but without any depressing after-effects. Give me something that will go straight to my cough control center, at the same time sweeping clear through my stomach and my system, too, bringing blessed relief in moments. I need an invisible shield, Doc, to protect me against germs . . ."

"What's that you say? Just go home and rest? You mean you won't give me any pills or medicines? No sprays, or drops even? For crying out loud, Doc, don't you ever watch TV? How do you know what five out of eight doctors prefer, if you don't watch the TV ads? After all, where do you think I got all my clinical knowledge—in medical school?"

Elements of Medical Practice

Some time ago an editorial appeared in the Minneapolis Star, was reprinted in the Kansas City Times, and quoted in part in some county and state medical journals. Being as true now as then, let us quote again: "A retail stores group has just completed a survey on loss of customers and the reasons are rather astonishing. One per cent die; 3 per cent move away; 4 per cent are classified as floater patrons; 5 per cent switch stores on the recommendations of friends; 9 per cent find they can buy cheaper at another store; 10 per cent are chronic beefers, but—get this—68 per cent of lost

*From the Wall Street Journal, Feb. 12, 1960; signed, David Savage.

customers blame it on the indifference of sales personnel."

Any professional man who feels that this does not apply to him should take a business inventory of his own office. How about the patients who disappear and then reappear in another's reception room and on the docket at another hospital? We all have something to sell, as does each of our employees. The voice over the telephone, the reception in the "waiting room," and the nurse behind the needle contribute to the patient's impressions of the physician and his ability to make the trip worthwhile. These contacts are so important that they have much to do with personal success and failure—and with the attitude of the people toward our profession.

The ancillary elements of medical practice and services are not elementary, and they should not be subordinated. May we be ever mindful of their significance and importance in our own practices and in the public relations upon which we depend.

More Prophetic Than We Knew

THE ROCKY MOUNTAIN MEDICAL JOURNAL for June, 1959, presented a leading editorial entitled "Sane or Insane?" It commented upon the extremes of psychologic states of human minds and physiologic variations in human bodies. Since medicine is not an exact science, opinions of physicians are often not in accord. Public confidence is thereby disturbed. Glaring disagreements in medical testimony color many trials, verdicts, and sentences. After asking whether an insane person is not more dangerous to society than one who is sane, we debated his worthiness to be forgiven because of actual or alleged insanity. Concluding in a lighter vein—at the time—our editorial asked why, in view of public disagreements among psychiatrists, the courts should not call upon enough of them to procure an equal number of verdicts for sane and insane, perhaps three yea and three nay. Obviously, the evidence would thereby be nullified. The suggestion was apparently taken more seriously than it was meant, or perhaps we evinced an uncanny premonition of things to come:

Large headlines in a regional newspaper of March 10 read "Verdict Is Reached in Inmate's Insanity." An angry District Court had as much trouble determining the sanity of a prisoner as the six psychiatrists who examined him. Three psychiatrists claimed he is insane; the other three had declared he is sane. Discussion by the jury in the deliberating room had been heated following courtroom revelation of the prisoner's career "from sex life to criminal record." Details of the opposing and numerically balanced medical testimony were published. The newspaper article was concluded with a sage remark by the defense lawyer to the jury, "I think you all realize experts can be mistaken. Somebody is mistaken here. . . ." According to an article in the paper the following day, the jury awarded the defense the benefit of the doubt and decided the prisoner is sane.

More recently, newspaper articles have discussed a new project within the police department. Police officers are to be given a course of instruction in judging whether their prisoners are sane or insane. The officers have every right to wonder who is going to teach them! If the plan works out, it will be interesting to note how their diagnoses line up with those of our colleagues. At least there will be more of them—and how could they do any worse?

In conclusion last June we said, "The attestants could get in a private huddle and study it out among themselves. Some interesting and revealing diagnoses might be forthcoming!" We should now bring our suggestions up to date, and also predict how the policemen will do in judging their fellowmen. If they, too, come out even with yeas and nays, perhaps they should simply draw up sides and shoot it out!

PLAN NOW to attend the 14th annual Rocky Mountain Cancer Conference in Denver on July 20 and 21. The Conference will feature outstanding speakers on topics of interest to every physician. Site of the Conference is the beautiful new Hilton Hotel, opened for the first time to the public in April of this year. Mark your calendar now for July 20 and 21. . . . Rocky Mountain Cancer Conference. Don't miss it.

Socialized medicine ... its un-American philosophy

Lanning E. Likes, M.D., Lamar, Colorado

Federal medicine is a threat to the American way of life. It could be the "death knell of democracy," destroying the freedom for which our country was founded. We must work and fight to maintain the standards which have made Americans the healthiest people on earth.

THE RECENT CLEARLY AND DEFINITELY STATED plan of the American Medical Association prompted me to write this article. The A.M.A.'s policy is clear. "It opposes national compulsory health insurance in any form because it believes voluntary enterprise can do the job a great deal better." Progress is not automatic. The world grows better because there are high-minded souls who wish that it should and because they will and dare to take the right steps to make it better. So we commemorate the efforts of great pioneers of medicine who felt that the scheme of human relationship was out of balance; capitalizing our gregarious or fellowship instinct, plus the altruistic desire inherent in most men to serve, they gave us organized medicine. To them we acknowledge a deep debt of gratitude.

We have heard much of medical economics during the past few years. We have thought a great deal about it; it has confronted us daily. Opinions have been formed and we have reached or attempted solutions of its problems. For the present, however, we must be unrelenting in opposing the advance of state medicine. Study, educate, instruct, inform—this must be the nature of our opposition. Defeat of the Forand Bill would be a step in the right direction. In the meantime, we can do no better than to engage ourselves in the important task of eliminating existing evils and incongruities. Such is our best defense against state medicine, for it will eliminate the necessity of its establishment. Our program does not compromise or modify the type of medical practice which preserves the personal relationship between physician and patient, which maintains the practice of medicine as a profession, and that has stood the test of centuries. The best interests of both the public and medical profession depend absolutely upon its preservation.

Play and umpire, both?

There is a place for government in medicine. It is the place of the government to govern, to decide the rules under which the game shall be played. *It is not the place of the government to make the rules, play the game, and umpire all at the same time—while at the same time making people pay, most often excessively, for participating in the spectacle.* Doctors must practice medicine because that is their job. They know how to practice much better than economists, legislators, or politicians. No system yet devised for entrance of government in medicine will work or satisfy the people unless physicians find it workable and capable of permitting satisfactory service.

The finest ideals will not propagate them-

selves. In organized medicine we have the happy combination of high ideals plus systematic organization. Individuals may worthily desire to serve and build, to imbibe deeply of friendliness, tolerance, and understanding. But alone they fail to impress the armored hide of indifference, selfishness, hate and bigotry. Men and women similarly imbued are fortified by an exchange of ideas and mutual helpfulness in a splendid association —our A.M.A. Our parent organization provides for us an array of leadership, experience, facts and literature which it binds together in a union which has become an integral part of a great altruistic force for human good.

Individuality or regimentation

Two widely antagonistic forces are striving for dominance in America, even more conspicuously since the Franklin D. Roosevelt administration. On one side is desire and ambition of the individual to live his life, carry his own responsibilities, and secure the utmost mental and material development. On the other is the ambition of some politicians to have people subjected wholly to herd ideas, whether to their best interests or not. They evince a personal sense, necessarily imperfect, that the way the herd is directed is also the best way. The contest is between individuality and regimentation. While regimentation with its attendant oppression has secured a high place in decadent nations of Europe, it should be fought bitterly in America, which has grown great through private initiative. This conflict is especially apparent in the present trend toward state medicine. In 1936, I spent seven months in Vienna and it was then evident what socialization was doing to medicine in Austria.

What is socialized medicine? It is a broad term, for anything is socialized which is supported by people as groups rather than as individuals. Given many different names, it is sometimes called state medicine, which indicates that medical services are furnished by government employees who are paid out of tax funds. When we think of socialized medicine, we assume that it would cover everything. In practice, it does not work that way. Most medical plans cover only industrial workers. Independent workers, such as shop keepers, professional men, and farmers, are excluded. The reason is that, while it is easy to have periodic contributions deducted from the workers' pay envelope, it is difficult to make regular and predictable collections from the self-employed. In Germany, where it has been in effect since 1883, only about 45 per cent of the population is covered. In Great Britain, where the plan began to be operative in 1911, 39 per cent is cared for. Taxwise, this is manifestly unfair, for there is a disproportion between the number who will pay and the portion who are benefited.

America is now leading all other nations in the extent and quality of medical research. Perhaps this is due to the fact that physicians in other countries do not have the time to carry on such work. The profession is not fighting socialized medicine to preserve its own existence. *It is fighting to keep the hands of the politicians from controlling the practice of medicine to the detriment of the health of the American people.*

Politics enters more or less—usually more —into the management of socialized medicine. Its diagnostic service is inferior, morbidity rate is greatly increased, and the mortality of nearly all of the important diseases is greater than under private practice. In no other country of comparative size and population is the average length of life as long, nor is it growing as rapidly, as in the United States.

Cold facts of science

Under private practice as it exists in this country, there is one other feature which, in the opinion of most physicians and most patients, adds greatly to the quality of service— the personal relationship between patient and doctor. It has become fixed in the customs of our people, and it will continue until destroyed or changed by law. One well-trained physician may be as able as another to apply science in treatment of disease, but times come in the lives of each one of us when cold facts of science do not avail. The personal side of the practice of medicine, which has always played an important and comforting part, enters at such times and renders a service which people desire and demand. Sympathy, kindness, pity and hope —no scientific efficiency can take the place

of these in dark hours of sorrow and trouble. President Elliot of Harvard said, "In these intangible things are found the durable satisfactions of life. Fame dies and honor perishes, but loving kindness is immortal."

I would not belittle science in medicine. I bow in humble reverence before its beneficent power. But it would be difficult to magnify the personal element in its application. Everyone knows what comfort, hope, and assurance the personality of a trusted physician brings to the bedside of his patient. Socialization practically destroys the personal element; it places all emphasis on the scientific side. Divorced from the personal element, effectiveness of science is immeasurably weakened. Our system of private practice blends the two into one service, and thus the medical care received by the American people is the envy of the rest of the world. In no other country has medicine so well brought health, happiness, and length of days to the fleeting span of life. For the present, however, we must be unrelenting in opposing the advance of state medicine.

The American people are proud and do not wish some political bureau to enter their home life, administer their routine in illness, and invade their privacy. Federal medicine would impose a tragedy upon the American health record—the best in the world. By means of a calm, dispassionate marshalling of facts, let us redouble our efforts to convince the public that socialized medicine is poorhouse medicine.

Some physicians are reputed to be untroubled by invasions into the practice of medicine, for they have commercialized their practices and succeeded in enriching themselves. Some are reported to have linked their abilities with political possibilities and will be "on the ground floor," no matter what happens. Others are possessed of an innate ability to be deaf, dumb, and blind to all but immediate problems of teaching or research. Offsetting these, we have in our ranks the priests of medicine—self-sacrificing, faithful and loyal. Such diversity of temperament is possible only because of the democratic nature of medical organizations. In the present emergency, however, petty differences and small jealousies must be laid aside in the interest of united action on behalf of preservation of the present system and for the welfare of our entire nation.

With hesitation I use the following apropos quotation, though unable to find its author:

"May we ever measure up to our duty, may we continue, as heretofore, to practice and exemplify the true spirit of altruism. I feel encouraged and have every incentive to be confident that we will never falter nor tire, since after all I agree as all true physicians do with Pasteur of old, who said that he held the unconquerable belief that the future belongs to those who serve humanity best." •

Fun costs twice as much as health care

Americans are spending twice as much money for recreation, alcoholic beverages and tobacco as they are for medical care, the Health Insurance Institute reports.

Two out of every 18 dollars the public spends for its personal needs goes for recreation, alcohol or tobacco compared to an expenditure for medical care of one out of every 18 dollars, said the Institute.

According to data based on 1958 figures and released by the U. S. Department of Commerce, Americans spent $293 billion on their personal needs.

Some $17 billion of this sum, or 5.8 per cent, was spent for recreation while $9.2 billion (3.1 per cent) went for alcohol and $6.3 billion (2.1 per cent) was used to purchase tobacco products, for a total of $32.5 billion, or 11 per cent of total personal consumption expenditures.

In comparison, $16.4 billion (5.6 per cent) was spent on medical care, stated the Institute. Other public expenditures in 1958 included $67 billion for food, $38 billion for housing, nearly $34 billion for transportation, $32 billion for clothing, accessories and jewelry, almost $4 billion for religious and welfare activities, and $3.4 billion for education and research.

The distribution of each dollar spent for medical care changed sharply in the period from 1938 to 1958, said the Institute.

In 1958, physicians and dentists received a smaller share of the medical care dollar than they did in 1938, while hospitals, medicines and appliances received a larger share.

From each dollar of the $2.7 billion spent for medical care in 1938, physicians received 30 cents, but by 1958 doctors were getting 26 cents out of each dollar.

Comprehensive psychiatric services for the State of Colorado

Franklin G. Ebaugh, M.D.*, and Herbert S. Gaskill, M.D.†, Denver

The problems of the State of Colorado in developing a comprehensive psychiatric care program are also the problems of the region. In context of modern knowledge, outmoded and incomplete psychiatric care spells a shocking failure of medicine to discharge its responsibilities to patients, and an equally negligent concern on the part of the community for its own welfare. Mental health efforts mean "too little and too late," while valuable community resources go to waste. This need not happen!

THE REORGANIZATION of Colorado's mental health facilities and services, actively studied and pursued during the past year by Governor McNichols' Ad Hoc Committee for Mental Health and similar committees of the Colorado State Medical Society, has gained impetus as a result of the recent consultative recommendations and endorsements of Dr. Paul H. Hoch, Commissioner of Mental Hygiene for the State of New York. His visit during the week of January 26 through February 3 seems, paradoxically enough, to have exerted both catalytic and stabilizing effects on the master planning and implementation of the program. This is an indication not only of Dr. Hoch's great talents and contribution, but also of the approaching maturity of the program itself. From the many opportunities for consultation provided by conferences and committee meetings with medical groups, and discussions with the Governor and key members of the Legislature, there derived an encouraging concurrence of opinion between the plan as it has been developed and Dr. Hoch's recommendations. Of particular significance is the probability that parts of the master plan can be implemented immediately, and that these advance developments can later be integrated into a fully-realized modern mental health program, as it is projected for the future.

The master plan

The major directions of development, as written into the master plan and crystallized during recent days of conferences, are the following:

1. Communicative and functional integration of mental health services for the State of Colorado should be undertaken with whatever degree of haste is consistent with vision and future ramifications. Obversely, fragmentation of mental health services should be eliminated. This necessity cannot be overemphasized. All mental health activities should be administered by a Director of Psychiatric Services in a Department of

*Formerly Director, Colorado Psychopathic Hospital, and Professor of Psychiatry, University of Colorado Medical School; Chairman, Governor's Ad Hoc Committee for Mental Health, and Chairman, Mental Health Committee, Colorado Medical Society.
†Director, Psychiatric Services, and Professor and Head of Department of Psychiatry, University of Colorado Medical School; Vice Chairman, Governor's Ad Hoc Committee for Mental Health.

Mental Health[1]. His concerns should include not only mental hospitals and community clinics, but also such activities of the Department of Health, Welfare, and Corrections as pertain to mental health.

The issues of mental health continue to be confounded, and their resolution impeded, by outdated legal and administrative connotations which do not operate in the field of general medicine. It is particularly for this reason that mental health must be aligned through a master plan which requires the dedicated participation of the over-all medical profession, organized medical societies, enlightened citizens' groups, and the Legislature. In order to meet the ultimate criterion of providing the optimum type, level, and length of voluntary treatment for every citizen of Colorado, from the moment that he displays a need for it, all of the mental health facilities must be interlocked both administratively and functionally. Patients must have freedom of movement from one service to another, in all directions, according to their individual needs. Doctors must have freedom of choice in prescribing treatment and forming working relationships with patients—in full assurance that the prescribed facilities will be available, and that they will be open to both patient and physicion. Only when the legal entanglements are cut and policies for the operation of mental health facilities rewritten can we approach the modern mental health goals of: (1) maximum voluntary patient admission; (2) maintenance of a consistent and continuous doctor-patient relationship throughout the course of treatment; and (3) maximum use of the community milieu through the predominance of open hospitals.

2. There are many possible compromises between a full, active, mentally-healthy community life for an individual and the near-total isolation of psychiatric hospitalization. Statewide psychiatry encompasses numerous services which offer friendliness, guidance, and opportunities for self-help as well as various types of specific professional therapeutic resources, along the path to and from the hospital. These include halfway houses, day-care centers, nursing homes, psychiatric clinics for treatment, follow-up out-patient care after hospitalization, "stress-graded" employment facilities, and provisions for careful screening and assessment of individual admissions to state hospitals. Many of these facilities can be organized at the community level, in fact must necessarily receive community attention and support. On the other hand, they should maintain interaction with psychiatric services at a state level.

3. In Colorado, the integrated services of two state hospitals will be available—one in Pueblo and the other in Fort Logan.

A. For the long-established Pueblo State Hospital, only a degree of modification of facilities and reorganization of services is required. The development of a 250-bed medical and surgical unit for acute treatment purposes is a necessity. In addition, a 150-bed intensive treatment unit will be established at Pueblo, through which the negative pattern of irreversible hospitalization can be considerably compensated; from this unit many admitted cases can be discharged to the community clinics for continued rehabilitative therapy after a relatively short period of hospitalization.

New beds needed

It is also anticipated that accommodations for 1,000 new beds will be constructed on a long-range program at the Pueblo State Hospital as a replacement for obsolete buildings now condemned. This plan does not imply that the hospital will be enlarged, for it is almost axiomatic that the custodial orientation of a hospital is often directly related to its size and understaffing. Thus, a large hospital is directly contradictory to the reversibility[2] of mental illness and long-term hospitalization which the mental health reorganization plan is intended to achieve. The Pueblo State Hospital will accommodate a population of 3,500, with rapid turnover expected for the larger percentage of patients. Furthermore, the emphasis will be on decentralization within the hospital; open wards and smaller units facilitate the sense of identity, the individual treatment plan, and the staff-patient relationships essential to satisfactory recovery from mental illness.

Decentralization within all treatment units, concomitant with integrated administration, free communication, and patient movement between centers, is the groundwork philosophy of modern mental health centers.

Central to this entire plan is the need for an imaginative and flexible recruitment program which can attract all types of professional personnel; i.e., psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, occupational therapists, recreational therapists and aides. With sound professional leadership which is now assured together with the coordinated planning of psychiatric services at a state and community level, it will be possible to attract the needed professional personnel. Energetic and carefully planned recruitment will be necessary to fully implement this program, since the best of organizational plans and additional buildings will have little meaningful impact on those suffering from mental illness. Human needs can only be met by the therapeutic efforts of trained professional personnel.

Community clinics planned

Patients of the Pueblo State Hospital will be treated not only on a residential basis, but also through coordinated community clinics, in which the psychiatric staff of the hospital (when obtained) will participate. It should be recognized as a fundamental principle that treatment rests as much with the community as with the State Hospital.

In line with the coordination of psychiatric services at all levels, thorough screening of all patients will be attempted, so that a comprehensive treatment plan can be evolved for each case, and referral to the appropriate facility can be made. This requires considerable change in commitment procedures, to permit greater flexibility in admission and disposition of patients. Currently, the Governor is appointing a joint committee of the Bar Association and the Medical Society to study commitment laws, and to make suitable recommendations for change. Such changes should permit continuous care of the patient through the necessary stages of diagnosis and treatment, completely through the rehabilitation phase. Thus, the physician with whom the therapeutic relationship was originally established will in many cases be responsible for the patient's entire course of treatment.

Thus, we may anticipate that the State Hospital in isolation may be relegated to history—a history which was perhaps necessary and even progressive at one time, but which is now better forgotten in the light of modern psychiatric concepts. Doctor X of the Pueblo State Hospital will now follow his discharged patient through the community clinic, insofar as geographical considerations and professional resources permit, preserving the smooth flow of recovery and the supportive encouragement of his relationship with the patient. Doctor Y of the Fort Logan Hospital can expect the same facilitation of the success and satisfaction of his work. From the patient's viewpoint, of course, this means comprehensive psychiatric services of the highest order.

Second hospital will help

B. More efficient and modern operation of the State Hospital at Pueblo will become possible, partly because of the creation of a second State Hospital at Fort Logan. As currently conceived, each hospital will be equipped and staffed to treat both acute and chronic cases; each will achieve a full-treatment coverage through attached community clinics; and each will be on a parity in contribution and function with the other.

It has been recommended in various conferences with legislative committees that 200 beds be provided at Fort Logan immediately, through the remodeling of existing barracks. Simultaneous construction of a completely new 250-bed hospital at the Fort Logan site should take place in accordance with the Guttersen plan. This means that Fort Logan should begin functioning about November 1, 1960, and achieve full operation within two-and-a-half to three years. The original temporary hospital will eventually become an annex, devoted to rehabilitative and other special activities.

4. As it is now formulated, Colorado's master plan for mental health reorganization anticipates the appointment of an Advisory Council by the Governor to establish: (1) administrative policy; (2) treatment proce-

dures; (3) patient movement and management; and (4) resident training programs for both Fort Logan and Pueblo.

While both State Hospitals will treat acute and chronic patients, operate attached clinics, and develop a statewide program based on modern principles of comprehensive psychiatric services, it is expected that only psychiatric patients will be admitted and retained in the hospitals. A definite percentage of the present senile population at Pueblo can be more properly reassigned to facilities (mostly nursing homes) in the community. The question of the use of foster homes as a more immediate resource should be considered. It is similarly anticipated that in the future only the alcoholic psychoses will be admitted. The mentally retarded will be more appropriately treated in separate institutions. It is recommended that patients combining the syndromes of mental illness with mental retardation be assigned to separate facilities provided on the grounds of the Pueblo State Hospital.

5. For the management of senile patients, who up to the present time have required an excessive number of beds at the State Hospital, a nursing home development directly under the authority of the Director of Psychiatric Services is anticipated. These homes should be greatly increased in number, equipment, and trained staff, and thus prepared to serve the chronically ill, the aged, and the many tractable psychiatric patients. It is anticipated that this development alone will greatly relieve the present overcrowding of the Pueblo State Hospital, and also facilitate the later development of small treatment units within the hospital. The more oriented to intensive treatment and the less concerned with custodial problems our state hospitals can become, the more effective will be their contribution to the Colorado mental health scene.

6. Plans are now under way for the erection of a day-care center for disturbed children at the University of Colorado Medical Center. Within the realm of the not too distant future are plans for a residential treatment center for children; the location of this facility requires further study. These developments, of course, recognize one of the most crucial omissions in Colorado's former mental health program.

7. The establishment of affiliated residency training programs for psychiatry through the University of Colorado Medical Center—programs which will help to staff extended mental hygiene facilities in both the present and the future—are well under way. For the Denver metropolitan and Tri-County area, clinic services will continue in integration with the Fort Logan facility, although extended residency programs will intensify communication and interaction between facilities. At Denver General Hospital, for example, acute treatment services will be closely associated with the activities of the Fort Logan Mental Hygiene Center. This is most important in its relevance to optimal patient care and movement. Denver General Hospital, with its 36 beds, admits approximately 600 patients per year, 40 per cent of whom are committed to the Pueblo State Hospital with only a 14-day hospital stay. It is anticipated that Denver General Hospital can continue to function, and much more effectively, for the purpose of short-term patient care if much of the admission load is redirected to Fort Logan. Colorado Psychopathic Hospital now admits about 1,000 patients per year, for an average stay of 34 days, and commits patients to the Pueblo State Hospital at the rate of about 10 per cent. This hospital, too, can be reinforced in its treatment and educational functions if it is no longer required to operate as a transitional facility.

Residency training

The reorganization of service functions, previously discussed in a different context, will be greatly assisted by extended residency training programs. With enough available professional staff, present and future, treatment functioning will increase and "stop-gap" activity disappear.

It is to be expected, also, that the Tri-County Mental Health Clinics can be expanded in their community services when the Fort Logan Hospital begins to function, thus providing senior, junior, and residency staff to the clinics.

In considering education and providing

greater manpower to the mental health scene, we must continue to focus also on encouraging greater participation by the non-psychiatric physician in all community mental health projects. Periodic postgraduate institutes should be held at Fort Logan for general practitioners throughout the state. Through these meetings, focus on the emotional factors in disease can be emphasized but, more particularly, concrete guidance can be offered to the general physician regarding his own community leadership role in implementing comprehensive psychiatric coverage for the entire state.

8. A master plan of this kind is necessarily sweeping in ramifications, not only for mental health activities, but also for related social and public welfare interests. As we have indicated, certain legislative acts and realignments are basic to satisfactory implementation of the plan, and these changes must be made thoughtfully and knowledgeably. The community Mental Health Act in force in the State of New York since 1954 not only provides useful legal guidance, but also demonstrates the valid relationship of such a law to more comprehensive modern psychiatric practice in the management of mental health problems. Likewise, modernization of admission procedures and encouragement of voluntary admissions should be part of new legislative acts.

Summary

In summary then, the following major changes in the State Mental Health Program have been recommended:

1. Separation of mental health administration from other state departments by the creation of a directorship of psychiatric services, through whom integration and communication can be facilitated. The manner in which individual community facilities are organized is considered to be of minor importance, provided a general director is invested with authority to establish over-all policy, and to offer consultation on organizational problems.

2. Development of transitional services to facilitate optimal movement and care of patients en route to and from the hospitals.

3. Decentralization of the existing State Hospital facilities through remodeling and reorganizing the Pueblo institution, creating an additional State Hospital at Fort Logan, developing integrated out-patient services and clinics in connection with both hospitals, and generally removing legal restrictions which hamper the flow of communication and voluntary admissions. Provisions for maximum interaction among treatment agencies must necessarily be written into the basic administrative policies of the state Mental Health Program.

4. Specialization of facilities, with emphasis upon providing optimal treatment programs for various types of mental health problems, notably those concerned with mental deficiency, senility, criminal insanity, definitive psychiatric categories, and emotionally disturbed patients who do not require hospitalization.

5. Provision of an adequate quantity and quality of nursing homes throughout the state, and the channeling of senile patients to those homes, thus relieving the State Hospitals of custodial functions.

6. Creation of adequate residential and day-care treatment centers for disturbed children.

7. Expansion of psychiatric facilities (for both hospitals and clinics) for the present and the future. The manpower problem can also be reduced by further encouraging the general practitioner to a leadership role in community mental health development.

8. Appropriate modification of Legislative Acts and restrictions, for purpose of facilitating development of a flexible, comprehensive mental health program in the State of Colorado.

More general goals consistent with modern psychiatric treatment cut across the specific recommendations in the master plan. These particularly emphasize decentralization of large-scale treatment centers into smaller units, flexible assignment of patients to treatment centers, administrative interlocking of mental health services, and community orientation in mental health treatment.

The general progress of the master plan for mental health through interest evinced by the Governor's office, the Legislature,

medical societies, citizens' groups, and those with special interest in psychiatric development seems to have been accelerated and complemented by the timely consultancy of Dr. Paul Hoch. One cannot but feel considerable optimism concerning the potentiality of this program for comprehensive psychiatric service which will interlock the hospital with the therapeutic resources of the community, make greater use of the talents of the general physician in evaluative and follow-up treatment procedures, and assure, by proper screening and adequate transitional treatment resources, that each patient receives optimal and appropriate treatment. Preventive treatment, earlier treatment, and therefore appreciable reduction of losses in manpower, money, and personal values are the possible result.

However, without the continued inspired participation of community and state leaders (professional, lay, and legislative), the master plan, with all its splendor and promise, remains but an abstraction without definition. Now more than ever, when the time is right and the prospects bright, there is need for dedicated work in implementing the plan to fullest effectiveness, in all its parts, throughout Colorado and the neighboring states.

Conclusion

In organization for mental health the solutions may be unique to the locale, but the goal directions are universal. The era of centralized, custodial care; of irreversibility in the course of mental illness; and of staggering waste in lives and dollars can be relegated to the past. Early and appropriate treatment in the milieu of the home community is the guidepost to the future. Legislative creation of a state-to-hamlet mental health administration which also facilitates free flow of patients between treatment centers is a primary consideration. The active leadership of general physicians in building and using resources at the grass-roots community level is equally vital. Through open hospitals, out-patient clinics, and rehabilitation programs, all of which can be attained through realignment of available services and manpower, mental health can be integrated into the community. The patient treated early and close to home, where the therapeutic power of his emotional and social "life-lines" can be maximized, is the patient who recovers. •

REFERENCES

[1]Hoch, Paul H., M.D.: Report on the Mental Health Program of the State of Colorado, February, 1960.

[2]Ebaugh, Franklin G., M.D.: Mental Illness, Reversible and Irreversible, The Journal of the American Medical Assn., September 26, 1959, Vol. 171, pp. 377-380.

The surgical abdomen in pregnancy*

Donald W. deCarle, M.D., San Francisco, California

Signs and symptoms may be modified or masked during pregnancy. Every physician doing obstetrics must be ever mindful of the differential diagnosis. An important comment is made about use of x-ray during pregnancy.

IN APPROACHING ANY PROBLEM that involves the pregnant as opposed to the non-pregnant woman, whether it is surgical, medical, or obstetrical, there are certain generalities which must constantly be kept in mind. The first, and probably the most important to the surgeon, is the progressive displacement of the abdominal viscera by the growth of the pregnant uterus. This results in a constantly changing position and relationship of the various abdominal structures. It also causes varying degrees of discomfort and at time, actual pain by stress and tension on certain tissue structures, such as muscles and ligaments. It becomes increased toward the latter part of pregnancy when uterine size and accompanying volume is at its greatest. Second, with our present knowledge, we have come to recognize an ever-enlarging number of modifications of physiological functions during pregnancy. This includes the so-called physiological anemias, the relative leukocytosis, the increased blood volume, and the multiple alterations in function of the glands of internal secretion, to mention a few examples. Finally, there are the many psychologic and emotional changes which cannot be overlooked in arriving at a diagnosis or carrying out treatment, either surgical or otherwise, in the pregnant female.

For simplification in the present discussion, the various complicating factors which could conceivably require intervention by abdominal surgery in the pregnant woman should be divided into two main groups. The first includes only those conditions which are directly related to the pregnancy itself. All other causative agents, including conditions coincidental to or accidentally associated with a pregnancy, are placed in the second of these two main groups.

Group I

Although this discussion is primarily concerned with the accidental complications found in the abdomen during pregnancy, there are several surgical conditions directly due to the pregnancy itself which should receive at least brief consideration, even among the general surgeons. By far the most important of these associated with early pregnancy is the so-called ectopic, or preferably tubal, gestation. It may manifest itself in so many ways that in the presence of any pelvic condition in a woman of childbearing age, even in the absence of a disturbed or modified menstrual period, the question of a possible ectopic pregnancy must be ever foremost in the mind of the examiner.

As opposed to the laboratory findings and those obtained by curettage which are helpful in a comparatively small per cent of these patients, the most valuable diagnostic procedure, in our opinion, is the posterior culpotomy. The technic is comparatively simple. The presence of free blood in the abdomen can be demonstrated by this method. The adnexa can be palpated digitally and even fairly extensive pelvic surgery can be carried out through this same opening, as shown by

*Presented before the 1959 meeting of the Ogden Surgical Society.

Bradbury and others.

Surgery is the indicated treatment in all patients with tubal pregnancy. Salpingectomy and occasionally more extensive surgery may be necessary. An associated appendectomy should be avoided in the majority of these patients. The only two patients in this series, in which tuboplasty was attempted, as suggested by Stromme and Thompkins, required a second operation. One word of warning in connection with this complication, which cannot be too frequently emphasized, is the routine check of the Rh factor, previous to all transfusions in patients such as these. In all emergencies, when time does not permit, Rh negative Group O blood only should be employed.

Among the surgical complications of the late gestational period directly due to the pregnancy itself there is, on rare occasions, one associated with placenta accreta which should be called to the attention of the general surgeon. In the presence of a so-called percreta, the placental villae may actually perforate the uterine wall, involving the neighboring structures. There were none of these in this particular series, but two such cases were recently reported at the San Francisco Gynecological Society. In both patients, severe bladder symptoms appeared with an associated hematuria. Both required hysterectomy with partial removal of the bladder wall.

Two other conditions in this group, which do not warrant detailed discussion at this time, but with which anyone doing surgery should be conversant, are uterine rupture and abdominal pregnancy. Both are serious complications of pregnancy and both at times may become dire emergencies requiring immediate surgical interference. Of the former, there were but three in our series. All followed previous cesarean section. This complication is included primarily to call attention to the frequent presence of an associated hematuria. In a recent presentation, the late Dr. Cooley emphasized this finding as a definite diagnostic symptom. As to the second of these two complications, it is mentioned primarily to emphasize the importance of leaving the placental bed undisturbed at all times in the patient in whom this complication is found.

Group II

As opposed to the first major group, the second includes those surgical complications of the abdomen coincidental to the pregnancy. No attempt will be made to subdivide this group. It becomes rather a question of increasing difficulty in both diagnosis and treatment of many of the same complications in the more advanced stages of pregnancy and the early puerperium. This is probably true to a lesser degree in acute complicating lesions of the upper abdomen. Conditions such as acute gallbladder and perforated duodenal ulcer should be handled both as to diagnosis and treatment in a manner similar to that in the nonpregnant patient, according to Walker and Greany. However, according to these authors, one must keep continually in mind that all patients in this group have become so accustomed to various forms of abdominal discomfort, especially in late pregnancy, that they fail to complain of any real symptoms much later than the nonpregnant woman.

Acute appendicitis: Most authors agree that acute appendicitis is still the most common extra uterine complication requiring abdominal surgery. In spite of modern hospitals, radical surgery and antibiotics, Varney points out that disease of this organ still kills 217 persons monthly, according to the Bureau of Vital Statistics. Thus, all operators are uniform in their opinion that only early diagnosis and prompt surgical interference can avoid a serious outcome for both mother and child in the presence of an acute appendicitis. This requires constant suspicion of this condition, especially in the second and third trimesters and the early puerperium. Laboratory and x-ray studies may be of little help in obtaining a diagnosis. In the opinion of Bryan, who recently discussed acute appendicitis in pregnancy, the history, if carefully taken, is the most important factor in arriving at the correct diagnosis.

Douglas advises early surgical interference in the pregnant woman, especially in the third trimester, even when the signs and symptoms are relatively benign. Even though a certain number of patients may be operated needlessly, he feels the risk is insignificant compared to the possible tragedy which so

frequently follows "procrastination and subsequent rupture of this organ."

Bryan, who agrees with this advice, notes a 41.6 per cent of patients with normal appendices who received surgery. On the other hand, Krieg, who collected 200 cases from four Detroit hospitals, calls attention to a 2 per cent maternal mortality with a definitely higher correct preoperative diagnosis. In the latter, the results of delay in surgical interference are obvious.

There were three patients in the group at Children's Hospital in San Francisco with a ruptured appendix. All occurred in the third trimester. All mothers and babies survived, although premature labor in one mother began within a matter of hours following surgery.

Bowel obstruction: Even more serious but fortunately far less frequent among complications requiring surgical interference during pregnancy, is intestinal obstruction. It increases in frequency in the advanced stages of pregnancy and early puerperium. This may be the result of tension on bands and adhesions produced by the enlarging uterus. Other causes include those which result in bowel obstruction also in the non-pregnant woman, such as volvulus, hernia, tumors and occasionally intussesception.

The main problem is in diagnosis. Presence of the gravid uterus is a definite handicap and may frequently result in serious delay in recognizing this condition. Auscultation and palpation become increasingly difficult in the presence of an abdomen filled in part or completely by the gravid uterus. The usefulness of x-rays as an added diagnostic aid also may be minimized. This can result in a delay which may even be fatal, especially when small bowel is involved. Six such cases were reported from the Martha Hague Hospital in 1952.

As in the non-pregnant, the symptoms of obstruction are much more profound when the blood supply is involved. The case of one such patient was reported from the Stanford Hospital group. Within 12 hours of delivery, this patient complained of generalized abdominal pain with vomiting and distention. Symptoms of rapidly increasing shock were also present. The patient expired within a period of 48 hours in spite of treatment. Autopsy showed an extensive mesenteric thrombosis resulting from volvulus of an unusually elongated mesentery with a very narrow base.

Treatment of this condition is directed primarily toward release of the obstruction. It should be noted that one is definitely handicapped in the use of decompression methods in the patient well advanced in pregnancy. Von Geldern, in reporting some seven cases of intestinal obstruction, found that termination of the pregnancy was sufficient in three patients near term to relieve the acute symptoms without surgery. However, in two patients in this present series, all symptoms became accentuated and more apparent following delivery of the fetus. One patient operated twice, once early and again late in pregnancy, required a third laparotomy for relief from the same complication following delivery.

There were no fatalities in the group of cases reported from Children's. This can only be explained by early interference following the onset of symptoms.

Ovarian tumors: Tumors involving the ovary, discovered during early pregnancy, should be removed if solid or cystic and more than 10 cms. in diameter. The large majority of the latter which are of a size too small to be of surgical importance, are simple follicular or corpus luteum cysts. Many of these are either lost in the abdomen by the enlarging uterus or regress during the ensuing pregnancy. However, it should not be forgotten that torsion of the adnexa may occasionally occur with these same small tumors or even with a normal tube and ovary.

In Bell's experience, well over 80 per cent of ovarian tumors treated surgically are found to be cystic. The remainder are of the solid variety. Of the former, the most common in his opinion are cysts of the dermoid or pseudomucinous type. In the past five years at Children's Hospital, there were two out of the five dermoids correctly diagnosed preoperatively by x-ray evidence of calcium deposits.

It had been previously assumed that surgery within the first trimester, especially if the ovary containing the corpus luteum was removed, would be followed by spontaneous termination of the pregnancy. Recent ac-

cumulation of evidence has proved this assumption to be wrong. Placental function evidently begins much earlier in pregnancy than was previously thought, as shown by the discovery of chorionic gonadotropins in the patient's blood, even before the first period is missed.

Discovery of an ovarian tumor late in pregnancy can be treated by immediate removal. However, for the most part, cesarean section, with removal at term, is the method to be preferred in patients with advanced pregnancy, should the tumor create a dystocia. If delivery of the fetus from below can be negotiated, then removal of such a tumor in the puerperium is probably even more satisfactory.

Although almost any kind of an ovarian tumor may be found associated with pregnancy, malignant neoplasms are fortunately rare. One such tumor was included in this series. It was first discovered at some 28 weeks of gestation. Because of its rapid growth, radical surgery was advised with sacrifice of the uterus and fetus. The patient, however, survived only six months following surgery.

Uterine fibroids: It was only some three decades ago that fibroids, discovered in early pregnancy, were treated by immediate myomectomy. In spite of heavy sedation, a high percentage of the patients thus operated, promptly miscarried. There was one such patient who was treated in this manner at Children's in the past five years. Fortunately, she was carried to term with no further complications, and was allowed to deliver spontaneously.

Of the seven patients in this group which came to surgery, one required an emergency laparotomy at 36 weeks with a preoperative diagnosis of acute appendicitis. On opening the abdomen, a pedunculated fibroid of the anterior uterine wall was found. It was gangrenous and surrounded by a layer of fibrin. Five of the remaining six were treated by supravaginal hysterectomy at the time of cesarean section. A similar hysterectomy was performed upon the sixth patient in the immediate puerperium. A large submucous fibroid filling the entire vagina, thought at first to be an inversion of the uterus, was found at the time of delivery of the placenta.

For the most part, myomata associated with pregnancy are left undisturbed. Even at cesarean section, only those which are in or near the uterine incision are removed, unless the uterus itself is to be sacrificed. It has become an accepted fact that with the rapid growth of these tumors during pregnancy, they undergo a high degree of degeneration. As a result, a large percent of myomata return to a size definitely smaller than that found preceding the pregnancy.

Vascular accidents: Of the least common but nevertheless serious intra-abdominal complications of pregnancy, are the so-called vascular accidents. They are the result in part of the increase in pressure which affects the intra-abdominal vessels in these patients during the latter months of pregnancy and the immediate puerperium. Although any abdominal vessel may be involved, hemorrhages resulting from rupture of aneurysms of the splenic and renal arteries are two of the most serious. Both are associated with unusually high maternal and fetal mortality. In a recent discussion of this subject, Thorp collected 117 cases of splenic artery rupture in pregnant women since 1900. Of these, 93.6 per cent occurred in the third trimester. What is most significant is that only five of this group survived and of the five, only two were diagnosed preoperatively.

Sperling, although admitting the infrequent preoperative diagnosis of this complication, suggests three possible criteria which might be helpful. Of these, the first is the upper left quadrant pain; the second is the presence of a systolic bruit over the palpable tumor mass; and the third is a pulsating filling defect in the greater gastric curvature on fluoroscopy.

Although even more infrequent than rupture of the splenic artery, such an accident in one of the renal arteries can be equally, if not more, serious. Of 11 cases involving this condition, Thorp reports the survival of but three patients. Only two of the three babies survived.

Not one of the 11 was diagnosed previous to surgery or autopsy. However, this author suggests that abdominal distention with increasing shock and a palpable retroperitoneal mass, confined to one flank, may be helpful. All patients in his group complained of in-

tense pain in this same area.

The treatment in both these complications is immediate surgery. The uterus may be opened and emptied if it is sufficiently large to interfere with adequate exposure.

Discussion

It becomes highly important in closing to discuss briefly two phases intimately connected with the diagnosis and treatment of the acute abdomen in pregnancy. The first of these has to do with the choice of anesthesia and, the second, with x-ray as a diagnostic aid.

In the early half of the gestational period, should an intra-abdominal surgical procedure be indicated, an induction dose of intravenous pentothal from 250-350 mgms. or more is used, depending on the size of the patient. The anesthesia may then be switched to small divided doses of intravenous demerol, 10 to 25 mgms., combined with nitrous oxide. Should the patient be in shock from blood loss, cyclopropane is the anesthesia of choice. As an alternative, however, following a small induction dose of 50-75 mgms. or more of pentothal, intravenous demerol in doses up to 200 mgms. or more combined with Iorfan has been found to be both safe and effective.

In the latter half of pregnancy, spinal pontocaine, up to 8 or more mgms., given in 3 or more cc. of glucose and spinal fluid is to be preferred. The patient may then be tipped into Trendelenburg position and oxygen administered. By this method, comparatively little in the way of pressure drop has been found. Here again, demerol and Iorfan may be helpful, should the procedure be unduly prolonged as by a preliminary section.

As a final word, there is no doubt that the opinion of a large majority of doctors is swinging away from the indiscriminate use of x-rays at any time during pregnancy. However, on discussing the problem of x-ray for diagnostic purposes in the pregnant patient with various doctors in that field, one is left with the feeling that maybe the crusade against its use has been too severe. All are unanimous in the opinion that its use during the first three months of pregnancy should be avoided entirely, with few or no exceptions. Conservative and judicious use any other time in pregnancy is permissible and probably innocuous. •

Over 44 million enrolled in Blue Shield

More than 44,700,000 persons were enrolled in the various Blue Shield Plans located in North America as of December 31, 1959, the National Association of Blue Shield Plans recently reported. Total membership in the Plans reached 44,792,923 at the end of the past year, which represents an enrollment of 24 per cent of the total United States population and nearly 15 per cent of the total Canadian population.

"The net gain in membership for 1959 amounted to 2,217,667, which is significant improvement over the 1,096,203 gain for the year 1958," the national association also indicated in its year-end report.

Several Blue Shield Plans recorded impressive enrollment gains during the past year. The Blue Shield Plan serving the Province of Ontario registered a net gain of 379,092 members during 1959, while the Pennsylvania Blue Shield Plan added 247,435 members and the Chicago Plan 166,691 members. Also noteworthy is the fact that two Blue Shield Plans had enrolled more than 60 per cent of the population in the areas they serve at the end of 1959. The District of Columbia Plan has enrolled more than 68 per cent of the residents of the nation's capital, while the Delaware Plan has enrolled almost 61 per cent of the state's population.

"The acceptance of Blue Shield as a means of helping to pay medical-surgical bills is reflected in the growth of these Plans in the past decade. Blue Shield has grown from a membership of more than 16,500,000 in 1950 to its present figure only through the offering of a program that has continued to meet the demands and needs of the American public," the report concluded.

American Physicians' Art Association

The 23rd annual exhibition of art works by American physicians will be held June 13 through June 18, 1960, at the Miami Beach Exhibition Hall and Auditorium, it was announced by Lewis M. Johnson, M.D., President of the American Physicians Art Association.

Held in conjunction with the annual convention of the American Medical Association, the show will include over 300 works of art in oil, water color, sculpture, crafts, photography and lithography.

Participants and prospective exhibitors may obtain further information from Dr. Kurt F. Falkson, 7 East 78th Street, New York City, Secretary of the American Physicians Art Association.

MATERNAL MORTALITY

The following cases have been reviewed by the Denver Maternal Mortality Committee and selected for publication because of their educational value. Submission of similar cases is invited from other committees in the Rocky Mountain Region.*

Case 1

This patient was a 26-year-old primagravida who was first seen by her physician in May at two and one-half months' gestation. Examination revealed no physical abnormalities except moderate ankle edema. Her B.P. was 110/70, weight 152 pounds, urine negative for albumin, and R.B.C. 3,700,000. Her pelvis was adequate. The edema subsided on a low sodium diet and she lost three pounds by her next prenatal visit. Pregnancy was uneventful until Nov. 15 when the patient developed a cough and low grade fever. Rales were heard in the right lung base. She was given penicillin and symptoms and signs promptly subsided. Ankle edema returned at Thanksgiving after the patient disregarded her low sodium diet and at her next visit to the physician's office on Dec. 13, she had gained five pounds and edema was conspicuous. Blood pressure at this time was 140/90 and there was four plus albuminuria. Patient was sent home on a liquid diet and bed rest and told to return on Dec. 16. She was seen on Dec. 17 and there was no change in her condition so hospitalization was elected.

On admission to the hospital, her B.P. was 144/92. Bed rest, sedation and laboratory studies were ordered. By 5:00 a.m. the next morning her B.P. was 180/110 and patient had passed only a small amount of bloody urine. Obstetric consultation was obtained and it was decided that despite the fact that the period of gestation was only 27 weeks, that a rapidly progressing, fulminating toxemia had developed and that the uterus must be emptied. Induction of labor by artificial rupture of the membranes and intravenous pitocin was done on Dec. 18. Medical consultation was obtained and therapy with antihypertensive drugs was instituted. The attempt at induction of labor was not successful and by the evening of Dec. 18 the patient was found to have a pleural effusion in the right chest; 600 cc. were removed by thoracentesis. Hypertension and oliguria persisted throughout the next day, and all consultants agreed that the uterus must be emptied by cesarean section—the patient not being in labor. An additional 1,400 cc. of fluid were removed from the right chest and at 4:00 p.m. on Dec. 19 cesarean section was done under local anesthesia. A live premature infant was delivered which lived eight hours. The patient did fairly well except that hypertension and oliguria persisted. The urine cleared of gross blood but microscopically red blood cells were seen. Although the patient was known to be anemic, transfusion was felt to be contraindicated because of the oliguria. The patient was placed on therapy with cortisone without any beneficial effect. Elevation of BUN was noted. On Dec. 22 the patient was given washed red blood cells I.V. Oliguria (120 cc. daily) and hypertension persisted with increasing BUN and uremia. The patient expired on Dec. 25, six days after delivery.

Autopsy revealed disseminated lupus erythematosis involving the kidneys, liver, spleen, lungs and heart. There was also massive terminal pneumonia in both lungs. The wound in the uterus was well healed and showed no evidence of infection.

Comment

It was the opinion of the committee that although the final diagnosis in this case was not established until postmortem examination, the patient received adequate and skilled supportive therapy and that death was due to the nature and extent of her disease rather than to any deficiencies in management and was therefore not preventable.

Case 2

This patient was a 26-year-old primagravida whose EDC was May 10, 1958, and who was first seen by her physician during the second month of pregnancy with influenzal pneumonia. Recovery from this was complicated by glomerulonephritis. Prenatal examinations at the third, seventh and eighth months revealed an elevated blood pressure of 132/96, edema and four plus albuminuria with hyaline and granular casts. R.B.C. on Dec. 29, 1957, had been 3,260,000. Serology was negative. X-ray pelvimetry done in the seventh month revealed a contracted pelvic outlet. The patient was hospitalized for study on Dec. 29 and 30, because of the edema and albuminuria. She was again hospitalized on April 7 for study.

*Committee Members: E. N. Akers, M.D.; Gerard W. delJunco, M.D.; George M. Horner, M.D.; Paul F. McCallin, M.D.; Leo J. Nolan, M.D.; James R. Patterson, M.D.; L. W. Roessing, M.D., and Ben C. Williams, M.D., Chairman.

R.B.C. on this admission was 1,710,000. Urine showed four plus albumin with hyaline and granular cases. Edema was present.

On April 19 the patient was brought to the hospital by her husband with history of having had labor pains for 12 hours. Examination on admission revealed general anasarca, elevated blood pressure and active uterine contractions. The membranes protruded through the vagina and were artificially ruptured. The cervix was partially dilated but the vertex was not engaged. The patient was given Demerol 75 mg. and trilene analgesia. Mercurhydrin was given I.M. in an attempt to reduce edema. Uterine contractions continued but there was no further progress and cesarean section was elected. A classical procedure was done on April 19 under pentothal-gas-oxygen anesthesia without difficulty and without excessive blood loss. A stillborn male infant was delivered. During the interval between April 19 and 21 the patient was given four liters of blood and one liter of glucose solution. On the first postoperative day she developed a temperature of 101° F., dyspnea and cough with bloody expectoration. These symptoms increased in severity and death occurred 12 hours later.

Comment

It was the opinion of the committee that the death was preventable. First, in view of the presence of acute glomerulo-nephritis early in pregnancy, it was felt that consultation should have been obtained with a view to terminating the pregnancy in the first trimester. Second, although information was not complete, it was felt that when the patient was hospitalized for observation in early April and found to be severely anemic, in addition to showing edema and albuminuria, supportive therapy should have been more vigorous and plans for abdominal delivery should have been made during this hospitalization rather than awaiting the onset of labor when the patient's condition had further deteriorated. Third, the transfusion of four liters of blood when signs of pulmonary edema were developing was seriously questioned. Since the purpose of the transfusion was to correct severe anemia, it was felt that packed or washed red blood cells rather than whole blood would have been preferable.

Write your Congressmen again!

Your representatives in Washington are strongly influenced by the apparent will of the voters. It is our duty to our patients, as well as to the medical profession, to voice a strong protest against Forand-type legislation, which is not dead yet! A colleague has sent the following letter to his Representatives and Senators:

I would like to enter my vigorous protest against the passage of any Forand-type legislation. My reasons are as follows: First, any government-controlled program does not have the flexibility to be successful for a high type of medical practice. Second, the political approach is repugnant to all members of the medical profession in this country. All of us who served in the Armed Forces during the war saw difficulties inherent in government controlled medical plans of any type. Abuses, political administration, and wastefulness were conspicuous. This is one reason why so many of us immediately got out of the Armed Forces. Third, and a very important point, is weakening of patient-physician relationship, which is one of the most valuable facets of medical practice. Fourth, every right thinking American prefers the privilege of choosing his own health plan from a private carrier so that he may suit it to his needs and pocketbook. Voluntary health insurance plans have fulfilled most of the needs of this country over the past decade and, granted the opportunity, will continue to improve their services and to provide better coverage to our citizens. Physicians are disappointed in many of the tax supported schemes for hospital and medical services with their loopholes, inefficiencies, and abuses of privilege. Efforts may well be directed toward improving existing facilities, such as the Veterans Administration, rather than the creation of new ones. Finally, I am in favor of anything which will keep the dollar sound and avoid political "give-aways" with their abundant iniquities.

As a faculty member of the University of Colorado for 20 years, I note that young men now applying to medical schools for study are fewer in number and substandard in quality. This situation has resulted in part from the threat of socialized medicine which makes the field of medicine repugnant to the better students. I have practiced medicine for almost 25 years but, should a government-controlled program dominate a major portion of my practice, I would be tempted to earn my living in some other way. Many of my contemporaries share this conviction. We would never allow ourselves to be responsible to a government agency for the amount of our compensation or for the quality of our performance. Such methods would be against the American way of life—which comprises the choosing of our own insurance plans, our own homes, the town in which we live, and our own physicians.

I urge you to make vigorous protest and exert your influence against any such legislation now and in the future.

Yours very truly,

Marshall G. Nims, M.D.

Comparable letters should go at once from every one of us. We cannot afford to leave it to the other fellow. Our opponents won't! Let each of us do his share of the campaigning before it is too late.

The first specific aldosterone-blocking agent...

ALDACTONE™

effectively extends the medical control of edema or ascites.
It introduces a new therapeutic principle in the treatment of...

CONGESTIVE HEART FAILURE • HEPATIC CIRRHOSIS
THE NEPHROTIC SYNDROME • IDIOPATHIC EDEMA

ALDACTONE introduces a new class of therapeutic agent, the aldosterone-blocking agent providing:

satisfactory relief of resistant or advanced edema even when all other agents, alone or in combination, are ineffective or are only partially effective.

A New Order of Therapeutic Activity

ALDACTONE acts by blocking the effect of aldosterone, the principal mineralocorticoid governing the reabsorption of sodium and water in the distal segment of the renal tubules.

By so doing Aldactone establishes a fundamentally new and effective approach to the control of edema or ascites, including edema resistant or unresponsive to conventional diuretic agents.

Further, because of its different site and mode of action in the renal tubules, Aldactone has a true, highly valuable synergistic activity when used with a mercurial or thiazide diuretic.

What Physicians May Expect of Aldactone

It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

When Aldactone is used in a comprehensive therapeutic regimen, which includes a mercurial or a thiazide diuretic, a satisfactory diuresis and relief of edema may be expected in approximately 85 per cent of edematous patients *who would not otherwise respond.*

DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of 100 mg.

G. D. SEARLE & CO.
Chicago 80, Illinois
Research in the Service of Medicine

ORGANIZATION

Abstract of Minutes*
House of Delegates of the
Colorado State Medical Society

Twenty-fifth Annual Midwinter Clinical Session
February 16 to 19, 1960
Shirley-Savoy Hotel, Denver, Colorado

FIRST MEETING

Tuesday, February 16, 1960

Vice Speaker Heman R. Bull, M.D., Grand Junction, called the House to order at 10:00 a.m. (in the Lincoln Room), and Speaker William M. Covode, M.D., Denver, and Vice Speaker Bull alternated in presiding throughout the meeting.

Dr. John A. Davis, Chairman of the Committee on Constitution, By-Laws and Credentials, presented the committee's report as printed in the House of Delegates Handbook and verbally amended it by stating:

"The Committee on Constitution, By-Laws and Credentials presents several names from component societies to fill vacancies and replace delegates and alternates not able to attend this session:

"Arapahoe County: Dr. A. E. Dahl is an alternate for Dr. James R. Leake. Pueblo County: Dr. Andrew Demshki to replace Dr. Harper Kerr, and Dr. Grant Curless as his alternate. San Juan Basin: Dr. T. W. Halley to replace Dr. Joseph G. McKinley as delegate."

The Secretary called the roll from the list of accredited delegates, and 52 (before adjournment increased to 74) accredited delegates (more than a quorum) answered roll call.

On motion duly made, seconded, and carried, the printed report of the Committee on Constitution, By-Laws and Credentials, as amended by the supplemental report, was adopted.

Vice Speaker Bull recognized the Speaker, Dr. William M. Covode, who delivered his opening address as follows:

Address of Speaker

"Welcome to the 25th Annual Midwinter Clinics. This will be short and painless. It is always humiliating, at a time like this, with a captive audience, to realize that you don't have any electrifying message to give.

"You have all undoubtedly read the foreword in the Handbook, urging serious and continuous deliberation to the matters at hand, so that we may compress our business into the two allotted sessions. Let me emphasize again that the proper forum for expression of opinion, especially today, is before the reference committees. They will meet promptly at 2:00 p.m. and will continue until their business is finished, we hope.

"The areas of dissent at a meeting such as this are always emphasized out of proportion, while the areas of accord are likely to pass by with little notice; and that emphasizes the fact that there are always two sides to the coin. It's like the truck driver who almost blew his top when he had to screech to a stop and barely missed a very obviously pregnant woman who was sauntering across the street; he leaned out of his cab and said, 'Listen, babe, don't forget, you can get knocked *down*, too.'

"Now, these areas of accord are generally reached through hard committee work, long before the meeting. It would not be a sign of weakness among any of you to quietly thank a committee member or chairman for his efforts.

"Finally, a personal plea. This is my third appearance in the role of Speaker or Vice Speaker, and I am continually haunted by the grim possibility of becoming entangled in a serious problem of parliamentary rule. So far that has not happened. So, please, will any amateur parliamentarians hold their fire for a little better occasion? I am not a worthy opponent, and I am afraid it would wind up in utter confusion. Thank you."

Trustees' and officers' reports

There being no objection, by unanimous consent the Minutes of the last Annual Session were approved as published in the November, 1959, issue of the Rocky Mountain Medical Journal.

The report of the Board of Trustees was received and referred as printed in the Handbook. There was no supplementary report.

The Speaker reminded all delegates that they should feel duty-bound to appear before any reference committee to present their views with regard to subjects under discussion, and that all members of the Society, regardless of whether or not they are delegates, are welcome to appear before any reference committee and present their views.

The reports of the Board of Councilors and the Grievance Committee were referred to the Reference Committee on Professional Relations. There was no supplement to either report.

The report of the Grievance Committee's Subcommittee on Panel Practice was referred without

continued on page 56

*Condensed from the shorthand record of Bertram Naster, Certified Shorthand Reporter. Reports referred to but not reproduced herein were distributed to all members of the House of Delegates at the 25th Annual Midwinter Clinical Session, in the printed "House of Delegates Handbook." Copies of that Handbook are on file with the Executive Office of the Society, and with the Secretary of each component society, available for study by any member of the Society.

Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

Ayerst®

5842

wherever there is inflammation, swelling, pain

VARIDASE®

Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery.

By activating fibrinolytic factors VARIDASE shortens the *undesirable phase,* limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection
...new simple buccal route

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.

Dosage: One tablet four times daily usually for five days

When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid.

Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

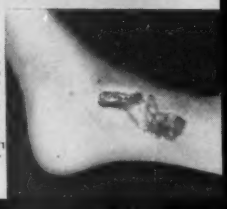
Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY
Pearl River, New York

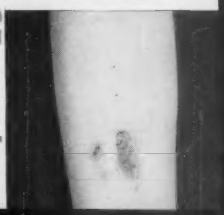
FORCE INJURY
severe bruises
... swelling
... cleared
by fifth day[2]

VARICOSE
ULCER
15 years duration
... resolved with
VARIDASE[1]

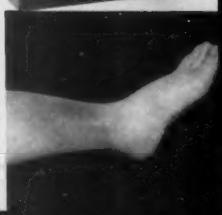


INFLAMMATORY
DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]

INFECTED
LACERATION
marked reversal
in 3 days...
returned
to school...
closure advanced[1]



THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]



REFRACTORY
CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]

supplement to the Reference Committee on Professional Relations.

Neither President McDonald nor any other officer who was a member of the boards which had reported wish to make a personal report.

Report of Delegates to the A.M.A.

Speaker Covode referred the report of the Delegates to the A.M.A. in the Handbook, to the Reference Committee on Professional Relations. Dr. Sawyer was not present at this time; however, the Speaker reserved to Dr. Sawyer the opportunity to make a supplementary report later in the meeting.

The printed report of the Executive Secretary was referred to the Reference Committee on Board of Trustees and Excutive Office.

Vice Speaker Bull: "Next in order are the reports of committees. Only those committees which are so requested by the Board of Trustees or the House itself report at your Clinical Session. All those which have been so requested are listed in order in the Handbook. These reports will be received and referred as printed in each instance, but I will also call upon each one in order, in case there is a supplement."

Reports of the Public Health Committee, Public Policy Committee, and Scientific Program Committee were referred to the appropriate reference committees.

Report of Blue Shield Fee Schedule Advisory Committee

Dr. John H. Amesse, Chairman, presented the following report.

The semiannual meeting of the Blue Shield Fee Schedule Advisory Committee was held last night in the usual robust manner. Two general subjects were discussed during the several hours of deliberation. After careful consideration, the committee recommends that the present assistant surgeon's benefit which allows for a flat fee for the assisting surgeon be continued for at least one year.

The second topic of discussion was informational and concerned the problems of the internist and the obvious gap between the desires of the internists and the policies of the Blue Shield Board of Trustees.

One resolution was unanimously passed: that Dr. Tom Mahoney be commended for patience and forbearance in his meetings as a representative of the Internal Medicine Society.

Vice Speaker Bull referred the Handbook report of the Blue Shield Fee Schedule Advisory Committee, as now supplemented by Chairman Amesse, to the Reference Committee on Insurance and Prepayment Plans.

Report of the Liaison Committee to State Welfare Department

Dr. Harry C. Hughes, Chairman, submitted the following report:

This committee was created by the Board of Trustees on November 21, 1959, and held its first meeting on November 27, 1959. Present at this meeting, as well as subsequent meetings, were the Director of the Welfare Department and members of his staff.

Because of the adoption for the "information and guidance of those concerned" by the House of Delegates, at its September, 1959, meetings, of the Morgan County resolution, which covered many points of disagreement with the administration of the Old Age Pension Medical Care Program, it was decided by the committee to discuss this resolution point by point in the presence of Welfare Department representatives. This discussion has been completed to the edification of the members of the committee, if not to their complete satisfaction.

The last of three meetings at which these discussions were concluded was held on January 22, 1960, by which date the House of Delegates Handbook had already gone to press. This is the reason for the submission of this verbal report today. In fact, another meeting of this committee is scheduled for tomorrow evening, Wednesday, February 17, for the discussion of three further points raised in discussions thus far, one of which is the matter of the obligation of the physician in cases of third party liability, when a pensioner is injured. This is largely a legal matter.

To summarize the discussions on all points raised by the Morgan County resolution here would be an unjustifiable encroachment on the time at the disposal of this House. Some points may be mentioned, however. Certain paragraphs of the resolution were rejected as being impractical. Some are already actually being followed, and some specific clarifying actions were taken.

There was agreement between the members of your committee and the Welfare Department representatives that the fee schedule for medical care of pensioners did not pretend to compensate for additional demands on the physician's time and energy made by relatives of the pensioner, and that the physician was justified and could expect, if he so desired, to hold the family responsible for any services rendered to them, as distinct from the medical care of the pensioner, just as special nurses and private rooms demanded by relatives must be considered their obligation. This information was disseminated to the members of this Society in the January 8, 1960, issue of Colorado Medicine.

A certain small number of physicians who are not now participating physicians in Blue Shield have also indicated their desire to reject participation in the Old Age Pension Medical Care Program. This is, of course, within their legal rights. Certain legal problems may arise, however, if these physicians accept as patients pensioners who are covered under the program and who assume the fees for their care by the non-participating physician are covered. The Welfare Department feels a legal obligation to protect the rights of pensioners under these circumstances and, therefore, raised the question as to how all pensioners could be informed beforehand who these physicians were.

Certain obvious solutions to this problem were, of course, regarded by your committee as highly undesirable. After much earnest discussion, your committee adopted a motion which suggests to the Board of Trustees a solution which should accomplish its intended purpose without any individual publicity. This suggestion will come before the Board of Trustees for action at its meeting later today.

The question has been repeatedly raised as to whether or not a physician is bound by the appropriate Blue Shield fee schedule, now Standard A, in the medical care of a pensioner. This was submitted to the Society's legal counsel, with the resulting opinion, properly documented by numerous actions of the House of Delegates in the past, that because of the contract signed by the Welfare Department and Blue Shield and by the participating physicians' agreement with Blue Shield, signed by the physician, that he is so bound.

Your committee has been repeatedly reminded, during the courses of its discussions, of one clear fact, to which it would at this time invite the attention of this House. When once the provision of medical care by government or any other agency is accepted, there is no alternative to the acceptance of some degree of regulation by the providing agency. The Old Age Pension Program is no exception. It is a part of the law of this state, by constitutional amendment voted by the people, and it is now our duty to comply with the law as good citizens, and accept what regulation is necessary and inevitable.

In concluding this report, however, it would be less than complete if it failed to state that, in our discussions, the Director of the Welfare Department and his staff have demonstrated in every way possible their desire to earn the confidence and cooperation of the profession.

HARRY C. HUGHES, Chairman
WILLIAM N. BAKER
DONN J. BAKER
ROBERT G. BOSWORTH
J. LAWRENCE CAMPBELL
FRED R. HARPER
ROBERT B. RICHARDS

The above report was referred to the Reference Committee on Insurance and Prepayment Plans.

Report of A.M. Delegates (Verbal Supplement)

Dr. K. C. Sawyer: "We want to reiterate that the House of Delegates of the American Medical Association at Dallas definitely cleared up the misunderstanding that came out of the Atlantic City meeting, where the medical care plans decisions were so misinterpreted by the press. They came out with a very strong statement of the free choice of physician.

"Most of the other business appeared in the Journal and covers almost everything. There is one point that wasn't adequately stressed in the report that came out of the A.M.A. headquarters. That was as to some of the stands that the House took. One was that the Council on Medical Education in Hospitals expressed a desire and put in a resolution that would place them directly under the Board of Trustees of the American Medical Association, and not responsible to the House of Delegates. This was defeated, because the reference committee felt that the present method, where the Council must answer to the House of Delegates, is far more democratic than putting this in the hands of just a few people.

"On the whole, it was a wonderful and effective meeting, because the principles that we stand for were strengthened, and big states like New York, for example, had a resolution in—they didn't quite have the nerve to follow through on it—where they exactly reversed their stand on doctors coming under Social Security. I think we are gradually winning the battle; the tide is turning the other way.

"I am sure you can get a lot of details that you would like to know more about, if you will consult the issue of the Journal that this appears in, and maybe Drs. Munro, McClure, Milligan, or Wiley could add something that we have overlooked, Mr. Speaker."

Drs. Munro, McClure, Milligan and Wiley had nothing to add.

Unfinished business

Vice Speaker Bull: "Next is unfinished business which has been printed in the Handbook. The House last September directed the Board of Trustees through the Ad Hoc Committee on By-Law Revision to make a special report at this time for your information and discussion, although no final action can be taken until the Annual Session next September. The Chair will now call upon Dr. Cyrus W. Anderson to present that report and open the discussion of it."

Dr. Cyrus W. Anderson: "Last September, when I took over the chairmanship of this committee, I had no ideas on this revision, no definite ideas as to whether the Society should be streamlined or not. I was just about in the position that a good many of you men are at the present time. But, being a dumb Swede, I have to have things graphically represented to me. The new Committee Manual that your President McDonald and the Board, through the Executive Office, have put out, helped. Each one of you has received a copy of it, and I hope that you have read it through from cover to cover. I know of no other way to get adequately acquainted with the workings of your Society.

"I think everybody is pretty well aware of the fact that the Society is getting along very nicely at the present time, under the present setup. However, it is getting a little bit more complicated every year, and in order to make a change you have to be looking ahead and making some preparations for a change, if a change is necessary.

"Now, in order to better understand the situation myself, I started making some rough drafts, organization charts, and other members of the committee submitted organizational charts, and I got together with Mr. Sethman and we finally arrived at two charts, really four charts, which we think will give you a better idea of the workings of the Society as it is now and how it would be providing this change is made at the Annual Meeting next September. We have these charts in slide form, too, but we have them here in color. The slides are not in color. I will explain a little bit about this and then show you the slides and explain a little bit more, if any of you have any questions."

(The organizational charts referred to were placed on standards, exhibited to the delegates, and explained in detail. They are being separately published for distribution to all component societies.)

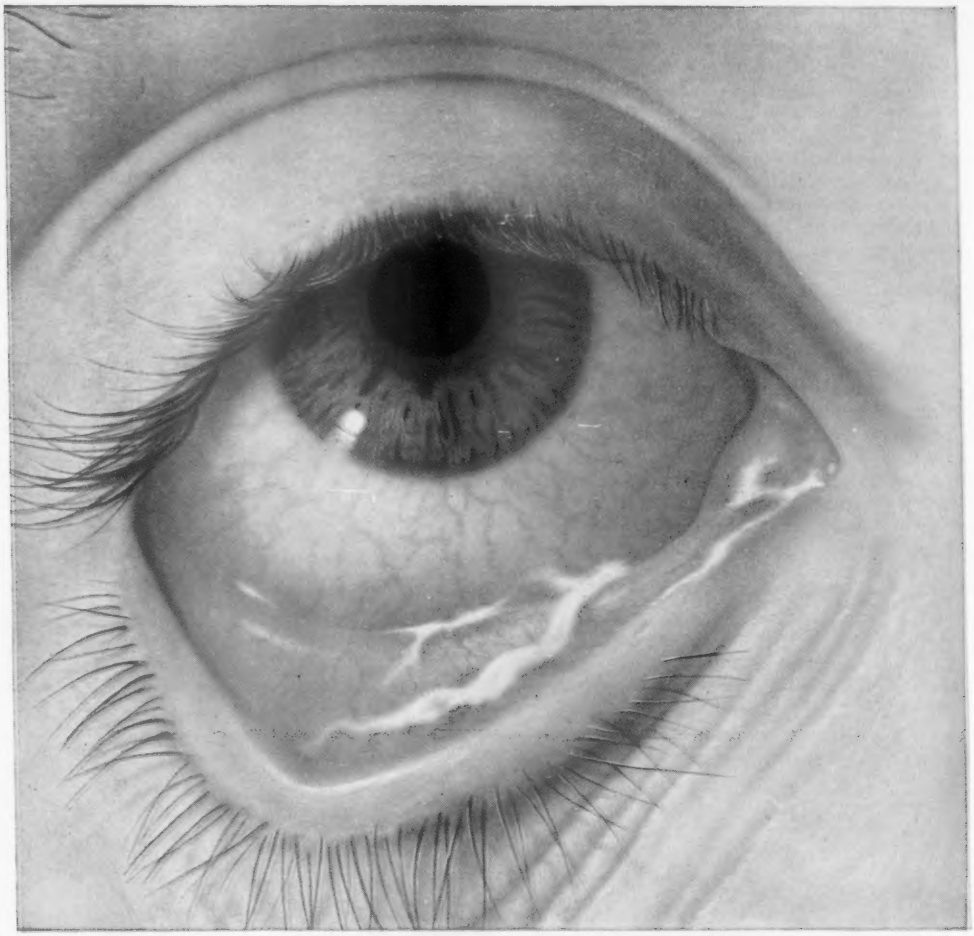
"Graphically, these charts tell more than thousands of words. I can understand it a lot better this way, and I'm sure that you can. These charts will remain up here so that you can study them and they will also be at the Reference Committee, so that anyone wanting to ask questions can do so."

Speaker Covode: "Are there any questions from the floor at this time? (Pause.) I think Mr. Sethman would like to add a few words to this discussion."

Secretary Sethman: "My thought has nothing to do with the pros or cons of this proposal, except to urge that the House of Delegates, through its reference committee, make at least a tentative decision at this Midwinter Clinical Session. Granted, you cannot amend your By-Laws at any meeting other than an Annual Session. Therefore, you can certainly not take any final action at this meeting. However, something occurred to me as Dr. Anderson was talking—something he probably wouldn't care to bring up himself—that he, as President-elect, and the Board of Trustees as now constituted, will be in a considerable quandary if they go away from this meeting not knowing what the House of Delegates thinks about this proposal for reorganizing committees.

"Let's assume, for the sake of argument, that you go away from this session without any deci-

continued on page 60



no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

Organization cont. from page 57

sion, even a tentative one, and come into the September meeting and then adopt this proposal. Under the present By-Laws, the President-elect is required to select in advance the committees to serve under his administration, and submit them to the Board of Trustees for confirmation. That is a perfectly stupendous task, as any recent past President or your current President, Dr. McDonald, will tell you. It would mean that Dr. Anderson would have to select—and then the Board of Trustees must pass upon his selections—almost 300 members of the Society to serve on committees for next year.

"Then, if this were adopted, much of it would have to be done over again, as rapidly as possible, during and immediately after the Annual Session. If you, however, are of a mind that this plan should not be adopted next September, I believe your officers should know that, so that they would go ahead with those appointments. If it is going to be adopted in September, they could proceed with at least tentative selection on the new basis.

"You can't make a binding decision at this time, but under your By-Laws delegates assume office on February 1, so that other than as accident, the 'grim reaper' or unavoidable absence might require certain alternates to serve for delegates who are present now—other than that, this House of Delegates is exactly the same personnel as will serve in September."

Speaker Covode: "This will be referred to the Committee on Constitution, By-Laws and Credentials. I think it is an obligation on the part of each one of you to become familiar with the pros and cons of this proposal, and I would think also that it would be very advisable if this material, both the written proposals and the graphic demonstration of what it would mean, could be made available to all of the delegates."

Report of Blue Cross Board Representatives

Speaker Covode asked Dr. Samuel P. Newman, the Society's Senior Representative on the Blue Cross Board, to present his annual report, as follows:

Dr. Robert L. Harvey and I are your representatives to the Colorado Hospital Service, which is the official title of Blue Cross in our state. I believe it was Tolstoy who said, "The vocation of every man and woman is to serve other people." In no field of endeavor is this more true than in the field of health care. A keen sense of responsibility to the welfare of mankind is basic to a doctor's nature. Hospitals could not function with employees who lack this quality, nor could Colorado Blue Cross, for its service is but another facet to hospital and medical care.

It has been both my pleasure and privilege to serve on the Board of Trustees of Blue Cross for the past eight years. During this time, I have seen the Plan's dedication to service manifested in the dramatic growth of the Plan. In 1952 there were 64 Blue Cross member hospitals. Now there are 83. In 1952 there were 430,000 members. Today there are over 672,000

members, or more than 42 per cent of the eligible population of the State of Colorado.

In addition to this, the availability of Blue Cross benefits has been extended to include some 54,000 old age pensioners who received Blue Cross benefits through a working agreement with the Colorado State Welfare Department, and an estimated 40,000 servicemen's dependents eligible for benefits through the federal government's Medical Care Program.

Incidentally, adding those two figures up should give one a little time to think, because there are 94,000 people who have been made eligible to receive medical service, one way or another, through governmental agencies. The old age pensioner, incidentally, is not a member of Blue Cross. He carries a Blue Cross card and a Blue Shield card, but your Blue Cross and your Blue Shield actually act only as a fiscal agent for the state government and handle their money to simplify matters and to cut down some costs.

Incidentally, the over-all net gain in the membership in Blue Cross in the past year was, in round figures, 57,000 people. I can well recall when, at the close of the calendar year of 1952, Mr. Harley Rice, who was the past Board President, reported a total of 69,243 hospital admissions. In comparison, the hospital claims department of Blue Cross received some 178,000 patient admission notices during 1959, and in turn paid out over 17 million dollars to Colorado hospitals for the services received by its members. Our monthly payments now to regular Blue Cross members are approximately $1,500,000.00. There is an additional $400,000.00 paid on the old age pensioners, making actually about $2,000,000.00, or a little less, per month, that Blue Cross has to pay out in funds. When you stop to think about it, that's 24 million bucks a year, and that's quite a little!

Although the value of Blue Cross to the community can be interpreted in terms of payments for hospital services required by its members, the true worth of the Plan must also be measured in terms of the manner in which it serves all members, including those who are fortunate enough not to require care during any given period of time. The Plan embraces within its philosophy of operation an ardent desire to provide the entire community with the type of service that the public expects, and continually strives to improve upon its every internal procedure, in an effort to accomplish each job more efficiently and more economically. In this respect, as well as in growth, Blue Cross showed great progress during the past year.

The year 1959 saw the introduction of new electronic data processing systems, the installation of I.B.M.'s Ramac electronic computer, and a new teletype system between Blue Cross headquarters and the Denver hospitals. Incidentally, I understand there is a contemplation that the hospitals in Colorado Springs and in Pueblo may be added to this teletype system in this coming year. You may wonder: Why this? When a patient is admitted to the hospital, the hospital begins immediately to check and find out if that patient is truly eligible for his Blue Cross benefits. It used to take four to five days to find this out. By that time, much of the patient's service was given, and in many instances he was not eligible, and many difficulties arose. Now, through the teletype system, actually if there is something very urgent about it, it can be accomplished in a matter of a few hours, I believe actually down to a minimum of four. But, as a rule, the answer is given the following morning.

Old style hand-posting operations were abandoned to provide for this fast, modern punch card status file. These improvements, plus other new internal procedures developed during the past months, will enable the Plan to better serve the public.

I have been told that the concept of prepaid health care in this country dates back to the year 1887, at which time, in the state of Michigan, a Mr. Peter Conley prepaid his hospital, medical, and surgical care for an annual fee of $5.00. Times have changed. If this can truly be called the beginning, we can now view with amazement the prophetic action of Mr. Conley.

Today, over 123,000,000 Americans subscribe to prepaid health care plans, and of these citizens, more than 56,000,000 are members of Blue Cross. Each Plan in the nation accepts a conscientious obligation to serve the public of its community to the best of its ability. The Colorado Plan is no different. Its very existence is dependent upon its ability to meet the demands of a health-conscious public for a realistic and sound health care program, and at prices it can afford to pay.

Blue Cross in the future, as it has done in the past, will continue to search out new and better ways of serving the public.

During the past year, in round figures, it has cost about

5 per cent of the income to operate Blue Cross. We laid away practically nothing in funds this past year, and that means that we paid out about 95 cents of each dollar to hospitals for the beneficiaries, the subscribers. However, in the past 26 months, that is, at the last time of a rate adjustment, we have averaged laying away about 3 per cent to meet contingencies. At all times we have actuarial studies going on to determine where we are and where we are going. We do not, at the present moment, have any definite plans for any kind of rate adjustment, but you may be assured that we are studying it at all times through the machine that we have down there, with all the equipment going on, and at all times.

Now, it is obvious that if we continue to get increased costs, then we will some day have to raise or readjust rates. You cannot operate one of these organizations with less income than you have outgo. And, incidentally, on a national level, there is a program to consolidate much of the activities of Blue Cross, which I believe will be much of a benefit to the subscribers throughout the nation, because it will make it much easier for one to get benefits in another state than that in which he is a resident.

Another point: Outpatient benefits, in the past 26 months, have been taken advantage of in a tripled number. You may well know that outpatient benefits for injuries are available to patients within the first seven days after injury, up to a certain amount, the same as are these benefits available to injured patients in Blue Shield, in your office.

The number of rooms available in this state in the hospitals has not increased materially enough yet to affect the number of admissions of patients, and thus an increase in cost. However, in one of our southern cities, there has been an increase in the number of rooms, and also the per diem cost has gone up considerably. This may be an omen of things to come.

Report of the President of Blue Shield

Speaker Covode: "At this time I'd like to call on Dr. Harry Hughes to give his annual report as President of Blue Shield."

Dr. Harry C. Hughes, President of Blue Shield, presented the following report:

This required report to the House of Delegates—in fact, the many hours of time taken each year on Blue Shield matters by the Colorado State Medical Society—is ample evidence that the medical profession in this state recognizes and accepts its responsibilities in the development of adequate health plans. This atmosphere of progressive interest in matters pertaining to the economics of medicine is most encouraging to one such as I, who finds himself the newly elected President of a Blue Shield Plan covering nearly 700,000 members and old age pensioners. A Plan which anticipates benefit payments in the current year in excess of $1,000,000 per month is big business and involves grave responsibilities for those who serve as its officers and on its Board of Trustees. So I ask those of you who may have intended congratulating me upon this election as President of Colorado Medical Service, Inc., to extend as well your sympathy, which I may need—but most of all extend your support and cooperation.

The 1959 annual report of C.M.S., which constitutes a part of this report and which has been given to you—and which also will soon be distributed to all Colorado doctors—is self-explanatory and can be reviewed at your leisure. The emphasis in this report is on the element of change, as it relates to Plan progress during the successful years of Dr. Good's term as President. The report highlights the much deserved Certificate of Service award bestowed upon Dr. Good by our Society at its last annual session.

During that session the House of Delegates also approved two new Blue Shield Plans—Standard "A" and Preferred "A." A description of these Plans as to benefits, fees, etc., has been incorporated in a revised version of the Participating Physician's Manual, which was mailed to all doctors right after the first of the year.

These new Plans have been available to the public only since the middle of January. Early results of the voluntary conversion are very encouraging and give assurance that there need have been no concern over the possibility of a mass exodus of Preferred Plan members to the less costly Standard "A" program. The first conversion offer was made to one segment of the members on a direct billing basis with payment due February 1, 1960. This offer was by mail in the form of descriptive literature inserted in the envelope containing the members' quarterly billing notice. As is typical of all mail solicitations, the percentage of returns was small and the offer will have to be repeated periodically to be effective. However, conversion requests were received from 744 families in the first three weeks. A detailed breakdown of these requests might be of interest to you:

Thirty per cent of the requests were from Standard members upgrading to Standard "A."

Fifteen per cent of the requests were from Standard members upgrading to Preferred.

Ten per cent of the requests were from Standard members upgrading to Preferred "A."

Forty per cent of the requests were from Preferred members upgrading to Preferred "A."

Five per cent of the requests were from Preferred members downgrading to Standard "A."

The enrollment of new members and the conversion of group members will undoubtedly provide more dramatic results because in these categories personal contact by the enrollment staff is possible. However, an insufficient number of such contacts have been made to date for any significant pattern to be noted.

Mention of these new Plans recalls that their development and approval was the occasion for the withdrawal of a number of members of the Colorado Society of Internal Medicine as Blue Shield participating physicians. A covering letter which was mailed with the new Manual called attention to the fact that the in-hospital medical benefit section could be subject to change as a result of benefit refinements currently sought by a Special Committee of Internists and Blue Shield Trustees which has held several meetings in compliance with the directive of the House of Delegates. I regret that I cannot report that this special committee has a solution to the medical benefit problem. However, I can report sincerity of purpose on both sides and determination to develop some compromise of existing provisions which will be fair to both the internists and the Plan's members. These meetings will continue until some satisfactory settlement is forthcoming. We solicit the help of any physicians who have suggestions for the improvement of this problem benefit area.

The reports of Dr. Newman, Blue Cross Board representative, and Dr. Hughes, President of Blue Shield, were referred to the Reference Committee on Insurance and Prepayment Plans.

"You'll find this condition will clear up as soon as you return to your own planet, sir. You're picking up something pretty terrible on your antenna . . . TV commercials!"

heparinization

WITH

LIPO-HEPIN

(Heparin Sodium U.S.P., aqueous)

A PHYSIOLOGIC APPROACH TO THE TREATMENT OF THE THROMBOTIC PROCESS

Send for literature

LH400

40,000 U. S. P. Units per c.c

Lipo-Hepinette

a sterile, ready-to-use SINGLE INJECTION UNIT

DARWIN Laboratories

MAIN OFFICE: 4800 District Boulevard • Los Angeles 58, California

Lipo-Hepinette: Reg. T.M.—Hypovial Syringe—U.S. Patent No. 2,625,157

Supplemental report of the Public Policy Committee

Dr. V. V. Anderson, Chairman, presented a supplemental report of the Public Policy Committee, as follows:

The report of the Public Policy Committee printed in your Handbook indicates that the problem of mental health in the state of Colorado has been its most important and time-consuming subject. This continues to be the case.

Since your Handbook was printed, two meetings of members of the Public Policy Committee and its subcommittee of Senior Psychiatrists have been held with Governor Steve McNichols and Dr. Paul Hoch—one meeting at noon of January 30, and the other in the evening of the same day. It is proper and necessary that all of you be aware of these meetings since their eventual effect on the care and treatment of mental patients in Colorado may be great. A short resume therefore follows.

In a meeting of the whole Public Policy Committee with Governor McNichols in December, which followed a meeting of the Public Policy Committee, it was recommended to the Governor that the state mental institution in Pueblo be immediately furnished with new construction of 240 beds, and facilities in the form of laboratories, etc., to properly maintain them. The Public Policy Committee also recommended that all possible steps be taken to convert the former Fort Logan, which has become the property of the state, into another mental hospital—one intended not in any way to replace the Pueblo institution, but to be in addition to it. In addition, it has become apparent to the Committee of Senior Psychiatrists that eventually many further changes will be needed, such as several smaller clinics to serve given areas of the state, and which would be supervised by those officially concerned with mental health in this state. Such a plan would lower the population rate in the Pueblo institution, gradually, to somewhere near its supposed capacity of 3,500, instead of the 6,000 there now.

To place such a plan in operation will take a lot of work, a lot of time, and a lot of money, but it seems that in the long run such a plan would save the state all of this work, time, and money, and then some. It is also very important to note that in order to effect such a plan some laws would have to be changed. At the present time the state mental institution in Pueblo has to accept, whether it wants to or not and whether there is room or not, all of those persons who are so committed by any county in the state. It follows that the mental institution in Pueblo becomes cluttered with all kinds of mental cases, as well as cases which are not really psychotic. It is overcrowded, and the mere diversity and overcrowding makes proper, effective mental treatment extremely difficult.

In the December meeting, the Governor indicated that, in general, the above was his idea also, that he was in favor, and that he would rest any final word until he had had a conference with Dr. Paul Hoch, who is at present the Commissioner of Mental Health for the State of New York, a man of very wide experience in these matters, and in whose state the outlined plan has been effective.

On January 30, members of the Public Policy Committee and the Committee of Senior Psychiatrists met with Governor McNichols, together with Dr. Hoch. At that meeting, Dr. Hoch outlined his views and methods in the state of New York. He also gave a short review of his examination of the problems of mental health in Colorado. He also gave an outline of his idea as to what should be done to make the treatment of mentally diseased persons more effective, so that many more such persons could return to their communities than now do.

In essence, his ideas are very much like that outlined here. After his discussion, Governor McNichols indicated that he had the same idea, and also that it appeared that the Colorado State Medical Society, through its Public Policy Committee and its Committee of Senior Psychiatrists, also agreed. He emphasized that in order to start such a program, which really involves a great change in the treatment of mental patients, the cooperation, certainly, of the Medical Society, of each individual doctor, and of all persons concerned, is absolutely necessary so that the people may understand the importance of this problem enough to fully support it. Governor McNichols also emphasized that the State Legislature was then meeting, and that it was important that he have some indication in writing that the Colorado State Medical Society was fully in accord with this plan to present to the Legislature.

In view of this fact, and also that the problem was an emergency so far as presentation to this State Legislature is concerned, and thereby such a matter could not wait for an

official vote of this entire House of Delegates, it was at that meeting decided that the Governor would be given a resolution in writing, and that copies of this resolution would be sent to each member of the Legislature, the resolution indicating that the Colorado State Medical Society supported Governor McNichols in his representations to the Legislature as to the need for new and different facilities in the state of Colorado for the treatment of the mentally ill. This was signed by your President, and by the Chairman of the Public Policy Committee.

The bases for the signing of such a document were two—first, that the Public Policy Committee had voted, in formal meeting, in favor of this plan, and, second, that the Public Policy Committee, in the interim between House of Delegates sessions, acts as the representative of the Medical Society in emergencies such as this.

It is, of course, impossible to completely acquaint all of you with the details as they have transpired, but the general news has already appeared to some extent in the newspapers, and undoubtedly will appear more and more as time goes on.

The Public Policy Committee believes that this problem of mental health in Colorado is at the crossroads—from here on we either go the way we are, with inadequate treatment of the mentally ill, or we take the bull by the horns and change almost entirely our methods in accordance with more effective ways—at least as so shown by the states which have tried it, such as New York, Kansas, and a couple of others. In order to accomplish this renovation, it is very necessary that all doctors indicate approval of the idea, support it in their communities, and exert some effort toward passage of the proper laws and other necessities required to produce the plan.

It is well to mention that Governor McNichols has asked the Colorado State Medical Society for its opinions and support through its proper committees regarding this problem of mental health. Principally through the intense work of the Committee of Senior Psychiatrists, he has been definitely helped in coming to a possible solution, and also in instigating the plan for proper presentation to the Legislature. Regardless of our political party beliefs, it has been generally agreed among those of us who have met with the Governor that he is very sincere in his desire to see the mental health situation in this state improved. He has spent a great deal of time discussing it; he knows that improvements cannot be had without cooperation of this Medical Society, and it is up to us to help as much as possible.

In closing, it must be definitely emphasized that during all of these discussions there has been nothing but praise for the work that Dr. Zimmerman has done at the state institution in Pueblo. Dr. Hoch stated that he could hardly believe, without seeing it, the cleanliness, orderliness and general upkeep of the institution, considering the conditions of overpopulation there. The whole problem of mental health in Colorado reflects in no way upon the personal actions of Dr. Zimmerman, as this Society well knows. Considering the laws and conditions regulating his actions, Dr. Zimmerman is to be highly commended, as he has been by this Society, for his many years of painstaking work for the mentally ill in this state.

Your Committee of Senior Psychiatrists is to be highly commended—they have worked for about two years on this problem; they have so far gone a long ways toward revolutionizing the treatment of the mentally ill in this state, and the success of their efforts depends a great deal upon the actions of the members of the Colorado State Medical Society.

Speaker Covode referred the above report to the Committee on Legislation and Public Relations after questions by Dr. J. B. Farley, Pueblo, were answered by Chairman Anderson and President J. L. McDonald.

Dr. Anderson's supplemental report of the Public Policy Committee was referred by the Speaker to the Reference Committee on Legislation and Public Relations.

New business

Speaker Covode recognized Dr. W. A. H. Rettberg of Denver.

Report from Colorado Society of Internal Medicine

Dr. Rettberg: "I should like to preface this report of the Colorado Society of Internal Medicine

continued on page 70

relieves both stiffness and pain with safety... sustained effect

In 100 consecutive patients with the low back syndrome, Kestler[1] reported that particularly gratifying was the ability of SOMA "to relax muscular spasm, relieve pain, and restore normal movement, thus speeding recovery in a large majority of the patients."

RESULTS WITH SOMA IN THE LOW BACK SYNDROME*

*Investigators' reports to the Medical Department, Wallace Laboratories. (Total of 278 cases)

NOTABLE SAFETY—extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

RAPID ACTION—starts to act quickly **SUSTAINED EFFECT**—relief lasts up to 6 hours

EASY TO USE—usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

SUPPLIED—as white, coated, 350 mg. tablets, bottles of 50; also available for pediatric use: 250 mg., orange capsules, bottles of 50

1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.: J. Pharm. Exp. Ther. *127*:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. *76*:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. *76*:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics *2*:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)

SOMA™

(carisoprodol Wallace)

WALLACE LABORATORIES, New Brunswick, New Jersey

Organization cont. from page 65

with a few brief remarks.

"First, let me remind you that at the last session, the 89th Annual Session in September, 1959, the House gave us some directives and asked that the Colorado Society of Internal Medicine appoint a special committee to see if we couldn't clear up some of these difficulties with our fee schedule in the Blue Shield. The committee was therefore appointed by Dr. Robert Porter of Greeley, and consists of Autrey Croke of Colorado Springs, Robert P. Harvey of Denver, Thomas H. Mahoney, Jr., of Denver, and Edward S. Miller of Denver, with myself as Chairman.

"This House also asked the President of Blue Shield, who was at that time Dr. Fred Good, to appoint a committee to negotiate this with us. Dr. Good was on the committee as the Chairman, with Dr. Hughes, Dr. Larry Campbell, Dr. Warren Tucker, and, of course, the executive people of Blue Shield, for their advice.

"I should at this time like to thank Dr. Harry Hughes, the new President of Blue Shield, for his cooperation in this matter, in the negotiations which we have held, and his kind remarks concerning them.

"This is the report of the Colorado Society to this House:

"At the 89th Annual Session of this House in September, 1959, the relationship of Colorado Medical Service, Inc. (Blue Shield) with the Colorado Society of Internal Medicine was discussed and referred to a reference committee of this House which reference committee made certain, definite recommendations to aid in solving some of the problems of the specialist in internal medicine. The recorded transactions of the House of Delegates' 89th Annual Session contains the full report of the reference committee passed unanimously by the House. This report contained the following six pertinent directives. I want to assure you that the six quotations which I am about to read you are taken from this report and by removing these quotations from the whole body of the report, I am not changing the context or altering the general idea of the report. These directives were as follows:

"1. 'Your committee unanimously recognizes and admits that the internists are not now equitably compensated for their services as compared with other specialty groups, especially as compared with compensation for surgical procedures.'

"2. '. . . the Blue Shield plan was originally conceived as a surgical coverage, and . . . it has never, perhaps erroneously, been expanded to cover adequately non-surgical medical services. It is also increasingly obvious that the public wants a much wider and more comprehensive coverage.'

"3. 'Your reference committee recognizes that the services of the internists are not adequately covered by **existing** Blue Shield plans . . .'

"4. '. . . testimony further convinces your reference committee that the Colorado State Medical Society, through its various channels, should take more definite cognizance of these inadequacies . . .'

"5. '. . . a new avenue of approach to this problem is in order.'

"6. 'Since Blue Shield was originally conceived to cover surgical procedures, it has naturally been difficult to expand into non-surgical fields and progress is very slow. However, rapidly changing times make it almost inevitable that a more comprehensive and equitable medical plan of coverage will eventually be introduced.'

"Since the meeting of this House in September, 1959, a special committee of the Colorado Society of Internal Medicine has met once or twice weekly in order to devise some sort of fee schedule that might be applicable to internal medicine and non-surgical care in general. This committee of the Colorado Society of Internal Medicine has had three long negotiating sessions with a special committee appointed by the Presi-

dent of Blue Shield. Negotiation and debate between the two committees has been sincere and friendly, but I am sorry to report that we have arrived at a complete impasse. These negotiations have been reported in full detail at the Annual Midwinter Meeting of the Colorado Society of Internal Medicine held in Colorado Springs, January 22, 1960, and our membership there voted to continue with Blue Shield on a non-participating basis. The membership, however, also voted to continue negotiation with Blue Shield and emphasized that the Society is always willing to listen to any plan which Blue Shield may offer to us. You should know, however, that many internists at the annual meeting expressed themselves quite forcefully in stating that they had found that the status of non-participation was beneficial to them and that they also felt that their patients had no objection to this status, these patients have no objection whatsoever to dealing with Blue Shield directly. Therefore, most internists have come to the conclusion that we should either continue as non-participating physicians, indemnifying the patient for whatever Blue Shield will pay directly to the patient; or that the Blue Shield eliminate the service benefit principle as it applies to non-surgical illness. At the present time, the Blue Shield Plan does not cover adequately the needs of patients requiring an internist, and it is a dangerous thing to participate in a plan which purports to furnish a type of coverage which is actually glaringly absent. This could be solved by Blue Shield by simply removing the service benefit for non-surgical care which, after all, only amounts to 16 per cent of the entire Blue Shield dollar paid to physicians. It could be explained to the subscriber when he purchased the plan that only a very small portion of his dollar is paid out for this type of care and that he could, therefore, afford to have partial coverage for specialists' care which patients are demanding. In many ways, by removing the service ceiling, we would only be offering the subscriber an indemnity type of plan. The Blue Shield, however, does not wish to interfere in any way with the service principle. In lieu of an adequate and improved fee schedule, the Colorado Society of Internal Medicine therefore feels that we should continue as non-participating physicians.

"The Blue Shield feels that one of the stumbling blocks to establishing a better fee schedule for non-surgical care is that they do not have enough statistics and data to establish the incidence of this type of illness and, therefore, insufficient data for establishment of premiums. If this is so, we would like to suggest that the Blue Shield inform its policyholders of this situation at the time of the sale of the plan and to tell the policyholder honestly that it is impossible at this time to sell them coverage which will be both adequate and for which a premium can be estimated; that it is therefore necessary to sell them either a deductible or an indemnifying type of plan, if they wish to have the services of a heart specialist or some other specialist in internal medicine. Technological advances in our specialty have been very great and, in most cases, the public has been aware of these improvements. It will be sheer folly to continue opposing technological advance by not offering our patients adequate coverage for these newer procedures. These advances always increase the cost of caring for the patient and some provision must be made for this. The patient is not going to accept the dictum that what was good enough for father is good enough for us and that these new-fangled ideas are unnecessary. If premiums are to be held at their present level for the Blue Shield subscriber, then we would like to respectfully suggest that a better distribution and apportionment of the Blue Shield dollar as paid to physicians be made.

"It should also be reported here that the relative-value scale, which assigns a unit value to different types of procedures and work done by the internist, was unanimously approved by the membership at the meeting in Colorado Springs. The dollar value of each unit is to be determined locally by the internist. Such a relative-value scale has already been approved by the American Society of Internal Medicine. The Blue Shield has been submitted a copy of this relative-value scale and one of our proposed fee schedules was based on it. The Blue Shield rejected a fee schedule based on our relative-value scale. Although such a scale has not been approved by the Colorado State Medical Society, we feel it is extremely important for us to establish one since the Blue Cross has been devising a national hospitalization plan to cover large industry, which we understand will soon be in force. Rightly or wrongly, the Blue Cross plans cover some physicians' services, particularly laboratory and radiology services. Therefore, eventually we are going to have some kind of a scale that of necessity will apply to all parts of the country, but which will be flexible enough to permit some local differences. The internists feel that one relative-value scale applying to all members of the State Medical

Society would not be satisfactory, but that we need at least four separate categories for establishment of relative value in each: (1) Medicine; (2) surgery; (3) radiology; (4) pathology.

"Each of these four sections should have their own relative-value scale. All federal employees in the country will soon be covered by some sort of prepayment plan and, if we are going to offer effective coverage and adequate fees for this large group, a relative-value scale is almost a necessity."

The above report was referred to the Reference Committee on Insurance and Prepayment Plans.

Dr. John A. Davis presented a resolution from the Arapahoe County Medical Society, as follows:

WHEREAS, In the minds of many very thoughtful people, inflation leading to financial chaos is the greatest material threat to the people of the United States of America, and

WHEREAS, Although the degree which increasing costs of medical care contributes to inflation is very small, nevertheless it is significant, and

WHEREAS, It is apparent that some responsible group must take the initiative in showing the way to thrift and economy, and

WHEREAS, Several of the various groups contributing to the total cost of medical care appear not to be fully cost conscious; therefore, be it

RESOLVED, That the House of Delegates of the Colorado State Medical Society go on record of charging each member, and particularly the Board of Trustees, with the responsibility of seeking causes and remedies for every factor to any unnecessary cost of medical care; and be it further

RESOLVED, That our delegates to the A.M.A. be instructed to convey by suitable means to the House of Delegates of the A.M.A. at their June meeting the ideas embodied in this resolution.

Upon motion duly made, seconded, and carried, the above resolution was adopted.

(Vice Speaker Bull presiding.)

At this point in the proceedings Vice Speaker Bull appointed Drs. W. C. Service and V. V. Anderson to serve as Sergeants-at-Arms for the purpose of excluding any unauthorized attendants, at the same time inviting certain guests to remain and take part in an Executive Session, and then he declared the House to be in Executive Session.

The House was then in extended Executive Session where it heard confidential matters, following which Vice Speaker Bull declared the House to be in open session and directed the Sergeants-at-Arms to open the doors. The following actions taken in Executive Session were recorded for the Minutes:

(1) Motion made, seconded and adopted without dissent: "That the Board of Trustees be authorized and directed to proceed with a study of the retirement plan that has been presented by the gentlemen from Mississippi, and that this directive carry with it the authorization of the House of Delegates for the Board of Trustees to enter into such contract or contracts as it deems wise with a Colorado bank or banks of the Board's choice, and to enter into such other agreements as may be necessary to effect a retirement plan for members of this Society in the pattern of the Mississippi plan, should the so-called Keogh Bill become law."

(2) Resolution, regularly introduced and its adoption moved, seconded, and passed without dissent:

WHEREAS, Proposed legislation in the form of HR 4700

(The Forand Bill) has been introduced in the 86th Congress seeking to amend the present Social Security Act so as to provide for the purchase of selected "health services" by the federal government for Social Security recipients; and

WHEREAS, HR 4700 would greatly increase the federal tax burden for Social Security purposes; and

WHEREAS, Any increase in taxes becomes a burden on all citizens, adds to inflation, and diminishes the value of our currency; and

WHEREAS, HR 4700 is a political approach to a health problem; and

WHEREAS, A nationalized, federally controlled program of this sort would weaken the patient-doctor relationship; and

WHEREAS, A bureaucratic system for providing health services for the aged would inevitably result in political abuses and administrative waste; and

WHEREAS, Colorado has already developed a program of health assistance to the aged that is working well; now, therefore be it

RESOLVED BY THE HOUSE OF DELEGATES, That the Colorado State Medical Society reaffirms its opposition to the enactment of HR 4700 introduced in the 86th Congress by Representative A. J. Forand of Rhode Island.

There being no further new business, routine announcements were made by the Speaker and the Secretary and the House adjourned to reconvene February 17, 1960, at 4:15 p.m. in the same room.

SECOND MEETING

Wednesday, February 17, 1960

Speaker Covode called the House to order at 4:15 p.m. The roll call disclosed 52 accredited members of the House present, more than a quorum (later in the meeting this was revised to 70).

Upon motions duly made, seconded, and carried, Dr. Henry W. Toll, Jr., was seated as an alternate for Dr. Robert F. Berris, and Dr. J. M. Perkins was seated as an alternate for Dr. Charles G. Freed.

Upon motion duly made, seconded, and carried, the reading of the condensed minutes of the first meeting of Tuesday, February 16, 1960, was dispensed with.

Speaker Covode: "Does the Board of Trustees have any report to offer in addition to the reports submitted yesterday?"

President John L. McDonald: "I have a statement which was made by the Board of Regents of the University of Colorado, in reference to the agreement between the University of Colorado and the Denver General Hospital. I think that it probably should be introduced. It is rather too long to read. I believe that the Reference Committee on Legislation is going to report in part on it; and I would propose, therefore, that we defer any report until after that reference committee has made its report."

Supplemental report of Board of Councilors

Dr. John D. Gillaspie, Vice Chairman of the Board of Councilors, presented a supplemental report of the Board of Councilors, which Speaker Covode accepted as requiring no action by the House. The text of the report follows:

continued on page 76

The first synthetic penicillin available for general clinical use

FOR YOUR NEXT PATIENT WHERE PENICILLIN IS INDICATED

SYNCI

PEAK BLOOD LEVELS HIGHER THAN POTASSIUM PENICILLIN V

ORAL ROUTE PROVIDES HIGHER INITIAL PEAK BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G

IMPROVED ANTIBIOTIC ACTION FROM ISOMERIC COMPLEMENTARITY

SUPPLY: SYNCILLIN TABLETS–250 mg. and SYNCILLIN TABLETS–125 mg.
SYNCILLIN FOR ORAL SOLUTION–60 ml. bottles–when reconstituted, 125 mg. per 5 ml.
SYNCILLIN FOR PEDIATRIC DROPS–1.5 Gm. bottles. Calibrated dropper delivers 125 mg.

ED CONSIDER THESE 6 IMPORTANT THERAPEUTIC ATTRIBUTES OF

ILLIN™

potassium phenethicillin (POTASSIUM PENICILLIN-152)

ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE	*REDUCED RATE OF INACTIVATION BY STAPH PENICILLINASE*	*SOME STAPH STRAINS MORE SENSITIVE TO SYNCILLIN IN VITRO*

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

Organization cont. from page 73

The Board of Councilors met yesterday afternoon and approved the recommendations of the Denver Medical Society for several reclassifications of membership.

The Board also approved the Denver Society's action in denying waivers of jurisdiction requested by several Denver physicians who wished to have their membership originate in other component societies.

The latter action brought about a discussion from which the Board of Councilors wishes to offer a recommendation for consideration by the Committee on Constitution, By-Laws and Credentials between now and the Annual Session in September. There are instances in which physicians are in full-time employ of state or federal governmental agencies, which agencies maintain their central offices in Denver even though the physicians employed by them do not reside in Denver nor is their work limited to Denver. Rather, they are in fact employed for state-wide services. The Board of Councilors believes the Committee on Constitution, By-Laws and Credentials might well consider a By-Law amendment which would permit such physicians to originate their medical society membership in the county of their residence.

The Board will meet again in April to consider unfinished business originated at this session and any additional business which may arise between now and then.

Dr. Gordon Vandiver, Chairman of the Grievance Committee, presented a supplemental report of the Grievance Committee, as follows:

Advertising new offices

The Grievance Committee has received a number of complaints regarding announcements placed by physicians in local papers, concerning the establishment of offices.

The policy regarding this seems to vary widely throughout the state, and it was suggested that the Colorado State Medical Society consider setting up a maximum allowable policy in this regard. It is recommended by the Grievance Committee that such announcements be restricted to one insertion of a small advertisement no larger than an ordinary visiting card, carrying the usual information regarding type of practice, location of office, and telephone number. This is suggested as a guide to local societies and it is recognized that local component societies may desire a more restricted practice concerning this problem.

Dr. Vandiver: "We recommended this so that the House could direct us in either adopting or not adopting this sort of policy."

The following motion was made and seconded: That the House of Delegates adopt as a policy that announcements regarding establishment of practices by physicians be limited to the insertion of one small advertisement*, no larger than an ordinary visiting card, bearing the usual information regarding the type of practice, the location of the office, and telephone number. This is suggested as a guide to local societies, and it is recognized that local societies, some of them, may desire a more restricted practice concerning this problem. But this would be a maximum.

The motion was discussed at length by Drs. Barrows, Crawford, Vandiver, and the Speaker, and in answer to a question, Dr. Vandiver pointed out that this action did not concern itself with periodic "professional directories" supported by all physicians of a community and published in local newspapers for general public information. Following the discussion, Dr. Barrows moved to amend the motion by inserting the words "three times" after the word "advertisement" in the motion as read. The motion to amend was seconded.

By a show of hands, said amendment carried, 42 to 11, and by voice vote, the motion as amended then carried.

*Amended, see following paragraphs.—Secretary.

Reports of reference committees

The following reports were submitted by the respective chairmen indicated at the conclusion thereof. Unless otherwise noted, they were each adopted by the House without dissent, section by section, and then as a whole. Discussion was called for by the Speaker or Vice Speaker in each instance and there was no discussion except as indicated below.

Report of the Reference Committee on Board of Trustees and Executive Office

Your reference committee recommends the approval of the report of the Board of Trustees as carried on pages 8, 9, 10, 11 and the top of page 12 of the Handbook. We commend the Board of Trustees for the efficient way in which they handled our ever increasing financial dealings.

Regarding the required official visits of the State Society officers to the component societies, our reference committee recommends that the cost of all meals for these officers, including the medical society banquets and lodgings when necessary for these visits, be defrayed by the State Society. This is recommended because of the burden placed on a small host society to defray these expenses.

We reviewed with interest the new project of publishing the bulletin "What Goes On" and trust that at the end of one year's experience, we can better evaluate its place in our already crowded mail.

The new "Committee Manual" is welcomed with enthusiasm and we wish to commend our President especially, and the Executive Office for the completion of such a valuable aid to the streamlining of our Society's business.

Our reference committee recommends approval of the report of the Executive Secretary as carried on pages 16, 17,

18 and the top of page 19 of the Handbook.

The report of Mr. Harvey Sethman, our Executive Secretary, was carefully reviewed and our committee was impressed with the evidence of the efficient operation of the Society's office.

We appreciate how much time and effort will be required to delve into the records to prepare a historical "policy index" of the State Society. Its value is immeasurable and we endorse its eventual completion.

WARD L. CHADWICK, Chairman
S. M. PRATHER ASHE
J. S. BAXTER
RAYMOND G. BONDI
HOWARD T. ROBERTSON
PAUL B. STIDHAM
MILTON L. WIGGINS

Report of the Reference Committee on Legislation and Public Relations

Your committee recommends the acceptance of the entire report of the Medical Service Committee, appearing on page 19 of the Handbook. With special reference to paragraph 4, which deals with the Medical School and Denver General Hospital, your reference committee finds that there apparently was never any intention of discontinuing Denver General Hospital as a teaching hospital for graduate and undergraduate training. A renegotiation of an arrangement is urged and it is hoped that both sides will see fit to cooperate and bring about improved patient care and continued good medical teaching, all in accordance with the city charter.

Your reference committee recommends the acceptance of the report of the Public Policy Committee as appearing in the Handbook on pages 23, 24 and 25, with special commendation to our Senior Psychiatrists' Committee for their excellent work. We also feel that this House of Delegates should make public commendation to our Governor of the state for his cooperation with this committee and the State Medical Society in general.

Your reference committee received and studied the supplemental report of the Public Policy Committee as read on the floor by Dr. Anderson, and as supplemented by our President, Dr. McDonald.

Your reference committee studied the report of the Board of Trustees as carried on pages 12 and 13 of the Handbook, and recommends the approval of this portion of the report dealing with the Hill-Burton Act, mental health activities, and old-age pension problem.

TERRY J. GROMER, Chairman
VERNON L. BOLTON
WILLIAM CURTIS
WILLIAM R. LIPSCOMB
ROBERT E. McCURDY

(Ancillary to the report of the Reference Committee on Legislation and Public Relations, President John L. McDonald, at the request of the Speaker, read the summary of the report of the Board of Regents, which he prefaced by the introductory remarks following.)

Dr. McDonald: "Rather than burden the House with sitting through the reading of all of this, I think it would be sufficient to have the summary of the report of the Board of Regents, dated February the 10th, read at this time. My feeling is that it does not require any action; it is merely for information. That opinion is concurred in by Dr. Hughes."

"1. The Regents recognize the right of the city to unilaterally terminate the current agreement.

"2. The Regents regret the unilateral action of the Board of Health and Hospitals in recommending termination of its contract with the University of Colorado Medical School; in our view the contract has been and continues to be of great value in respect to the care of patients at the Denver General Hospital and to the University.

"3. The Regents believe that the University made a significant concession in accepting the position of the Board of Health and Hospitals on the separation of responsibility for patient care and teaching. The University cannot, however,

alter its position on the method of appointment or tenure without sacrificing essential principles; specifically, the University cannot accept an arrangement under which Division Chiefs are given tenure such as that provided by career service status.

"4. The Regents believe that severance of the University affiliation will be harmful to the quality of care provided to patients at Denver General Hospital and that any saving of money the city may effect will be at the expense of the quality of patient care.

"5. Any suggestion that the University is promoting merger of the Denver General Hospital and the Colorado General Hospital is without foundation in fact.

"6. The Regents reiterate that the University has not as yet had any discussions or negotiations regarding Hill-Burton support of the building program, but we undoubtedly will have at a later date in connection with the financing of the new center.

"7. The Board of Regents wishes to reiterate that there will be no compromise in University standards, whether in terms of faculty appointments or the quality of educational programs."

Report of the Reference Committee on Professional Relations

Your reference committee approves the report of the Board of Councilors as carried on pages 13 and 14 of the Handbook, and commends the Board of Councilors.

Your committee approves the report of the Grievance Committee as carried on page 14 of the Handbook, and commends the Grievance Committee.

Your reference committee approves the report of the Grievance Subcommittee on Panel Practice as carried on pages 14 and 15 of the Handbook. However, your reference committee recommends that future reports of this committee should specifically designate approval or disapproval of the prepayment or third party plans studied by the committee.

Your reference committee approves the report of the Delegates to the A.M.A. as reported in the January, 1960, issue of the Rocky Mountain Medical Journal. Your committee commends the Colorado delegation for their unceasing efforts in the "fight" for "Free Enterprise in Medicine."

GEORGE R. BUCK, Chairman
HERMAN C. GRAVES
ABRAHAM J. KAUVAR
JACKSON SADLER
WILLIAM R. SISSON
JOHN C. STRAUB

Following the motion to adopt the above report as a whole, Dr. Vandiver, chairman of the Grievance Committee, questioned the meaning of the third paragraph of the report and asked if the reference committee desired that lists of all approved and disapproved plans be published. Chairman Buck of the reference committee explained that the report of the Panel Practice Subcommittee in the Handbook had merely included a list and did not state what the subcommittee meant by it. Further discussion by Drs. Vandiver, Boyd, Perkins, and Shand followed, and it was pointed out that the list constituted a list of plans held to be operating within the Principles of Ethics as interpreted by the Board of Councilors. The report of the reference committee was then adopted.

Report of the Reference Committee on Insurance and Prepayment Plans

This reference committee recommends that the first paragraph of the Blue Shield Advisory Committee report, which reads, "The present assistant surgeon's benefit which allows for a flat fee for the assisting surgeon be continued for at least one year," be amended to read that "The present assistant surgeon's benefit which allows for a flat fee for the assisting surgeon be re-studied and re-submitted at the September, 1960, annual meeting."

The reference committee has had evidence submitted to it which indicates that the present benefit for the assistant surgeon is not satisfactory to some communities.

The reference committee approves the remainder of the Blue Shield Fee Schedule Advisory Committee report and moves the adoption of the report as amended.

The reference committee recommends approval of the report of the Liaison Committee to the State Welfare Department, as read by Dr. Hughes at the first meeting of the House of Delegates, and commends the Liaison Committee for its statesmanship in the conduct of its work with the Welfare Department. The committee wishes to commend Mr. Justis for his cooperation.

The reference committee recommends the approval of the report of the Representatives of the Colorado Hospital Service as read by Dr. Newman at the first meeting of the House of Delegates, and wishes to commend Dr. Newman and Dr. Harvey for their work well done.

The reference committee recommends the approval of the report of the President of Colorado Medical Service, Inc., as read by Dr. Hughes, the President of Colorado Medical Service, at the first meeting of the House.

In compliance with the directive of the House of Delegates in September, 1959, a special committee of internists and Blue Shield Trustees has held several meetings with regard to the medical benefit problem. While a final solution has not been reached, the meetings will continue until some satisfactory settlement is forthcoming. The reference committee commends Dr. Hughes for this report and wishes him every success as the new President of Blue Shield.

The reference committee accepts the progress report of the special committee on Blue Shield of the Colorado Society of Internal Medicine. While agreement on several proposed solutions has not been concluded between the representatives of internal medicine and the Blue Shield Trustees, the reference committee feels that continuing progress has been made. The wishes of the internists in regard to extension of non-surgical Blue Shield benefits have become widely known and negotiations with Blue Shield are continuing. The reference committee recommends that a report on the status of subsequent negotiations between the internists and Blue Shield be submitted by the special committee on internists at the annual September, 1960, meeting of the Colorado State Medical Society.

SAMUEL B. CHILDS, Chairman
V. V. ANDERSON
GEORGE H. CURFMAN
KENNETH E. GLOSS
H. E. McCLURE
J. ROBERT SPENCER

Report of the Reference Committee on Miscellaneous Business

Your reference committee recommends the approval of the report of the Committee on Public Health as carried on pages 20, 21, 22 and 23 of the Handbook.

We also recommend approval of the report of the Committee on Scientific Program as printed on pages 25 and 26 of the Handbook, and we commend the committee on the excellent program of this meeting.

L. L. HICK, Chairman

Secretary Sethman: "Mr. Speaker, since this last report of the reference committee concerns the Public Health Committee and its many subcommittees, it seems appropriate to announce to this House, and have it recorded in the minutes,

that your immediate past President, Dr. John Zarit, has just been appointed to the Colorado State Board of Health by Governor McNichols." (Applause)

There was no unfinished business to be presented.

Report of the Reference Committee on Constitution, By-Laws and Credentials

Your reference committee recommends approval of the report of the Ad Hoc Committee for Revision of the Constitution and By-Laws as carried on pages 27, 28, and 29 of the Handbook and the supplement of the Ad Hoc Committee on By-Law Revisions as carried on pages 29 to 36 of the Handbook, with the exception of the words "subject to approval of the House of Delegates" at the end of Section 3, Chapter VIII. The committee feels that this would require approval of the House of Delegates for all terms of office of the committees established by the Administrative Councils, which your committee feels is not necessary.

The committee recommends that the House of Delegates at this time declare its intention to adopt the proposed constitutional and by-law amendments, presented in the report referred to above, as the first order of business after organization of the House at next September's Annual Session, and that the House of Delegates authorize the President-elect and Board of Trustees to prepare nominations for presentation at the next Annual Session for all new offices to be created by the proposed changes in the Constitution and By-Laws.

JOHN A. DAVIS, Chairman
RAYMOND C. BEETHE
MARVEL L. CRAWFORD
WINTHROP B. CROUCH
TULLIUS W. HALLEY
H. HARPER KERR
ROBERT B. RICHARDS
FRED J. ROUKEMA

Dr. George H. Curfman, Jr. (Denver): "Mr. Speaker, I wonder if it would be in order to refer back to one item upon which no action was taken in this session, namely, the report of the Board of Regents, which was read by Dr. McDonald. This has been so much in the minds of the physicians, at least in the Denver community, that it would be worthwhile for us to affirm or disaffirm, disavow the action taken by the Board of Regents."

President McDonald: "The Board of Trustees and the Board of Regents met about two weeks ago to discuss, among other things, the unfortunate publicity that had occurred as a result of the disagreement."

"In that meeting, at which no minutes were kept, the Board of Regents promised that they would make a report disavowing several things, among them the charge that they had instigated plans for trying to divert all Hill-Burton funds available for aid in establishing teaching beds, to the University of Colorado. They maintain and, I think, show that they had not applied for any Hill-Burton funds.

"They explained their position in relation to the principal source of disagreement between themselves and the Denver Board of Health and Hospitals, which was over the selection of a Chief of Medicine for Denver General Hospital.

"When I said here that I read the summary for information and didn't think it particularly required any action, I also said at the same time that, of course, the House could request that further action be taken. I will be glad to read or have read the whole report, or I am sure that, if you wish, there are many people here who know a great deal about the whole controversy, who would be very glad to talk about it."

Speaker Covode asked if the letter from the Regents is going to be given publicity, and Dr. McDonald stated his understanding is that it was.

Discussion followed, at length, by Drs. T. J. Gromer, Gordon Meiklejohn, K. C. Sawyer, and R. P. Harvey, and Dr. Meiklejohn moved that the House accept the Regents' statement. The motion was opposed by several on the ground that adoption would merely amount to the House's belief that the Regents were truthful, and rejection of the motion would imply that the Regents were untruthful. On motion of Dr. Perkins the motion was tabled by viva voce vote.

Speaker Covode inquired of Secretary Sethman whether his official desk was cleared. Mr. Sethman certified that it was, except for final verification of the roll call, which he then proceeded to make by calling the list of absentees and entering as present any who then appeared. Interposed in this procedure were the following proceedings:

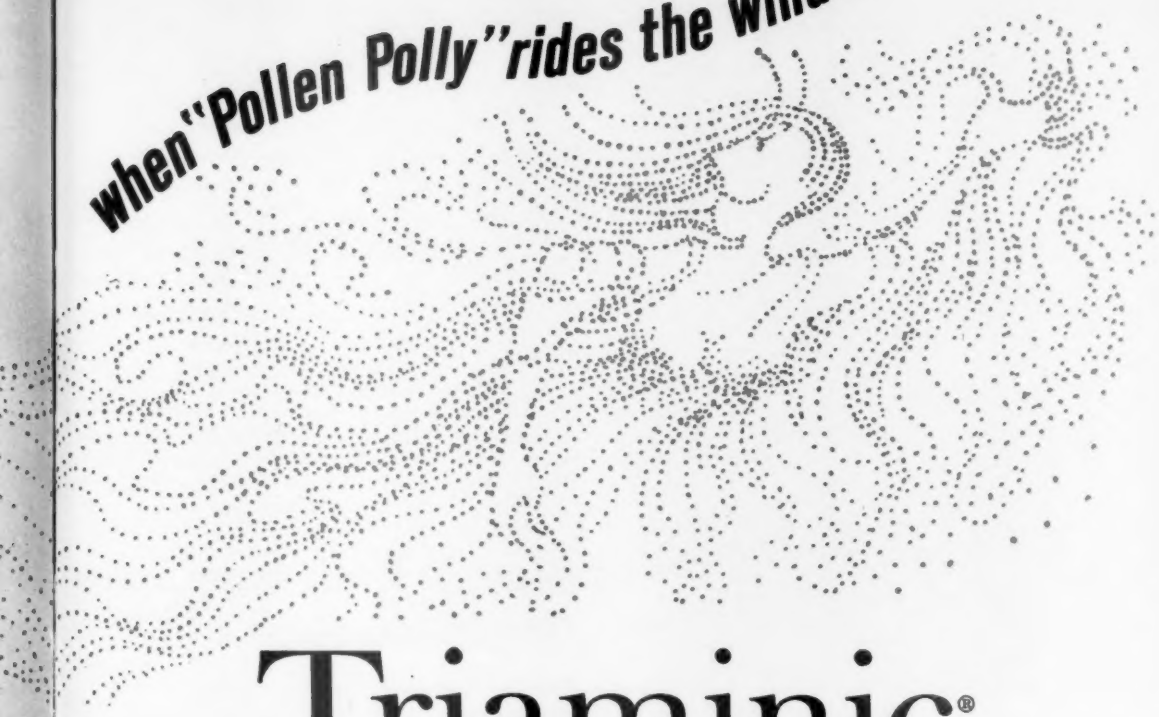
Dr. V. L. Bolton moved that the actions affirmed in the House by the Executive Session be reaffirmed in the House of Delegates*. The motion was seconded, put to a vote, and carried.

Speaker Covode then announced business had

*See page 72.

continued on page 83

when "Pollen Polly" rides the wind...



Triaminic®

...relief from pollen allergies

more complete than antihistamines alone... more thorough than nose drops or sprays

The miseries of respiratory allergy can be relieved so effectively with Triaminic.[1-5] Triaminic contains two antihistamines plus the decongestant, phenylpropanolamine, to help shrink the engorged capillaries, reduce congestion and bring relief from rhinorrhea and sinusitis.[1] Oral administration distributes medication to *all* respiratory membranes without risk of "nose drop addiction" or rebound congestion.[2,3]

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

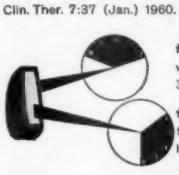
also available:

TRIAMINIC JUVELETS® ½ the formulation of the Triaminic Tablet with timed-release action.

TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

References: 1. Fabricant, N. D.: E. E. N. T. Monthly **37**:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. **7**:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy **18**:36 (Jan.) 1960.

Relief is prompt and prolonged because of this special timed-release action



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 **more** hours of relief

SMITH-DORSEY • A DIVISION OF THE WANDER COMPANY • LINCOLN, NEBRASKA

in infectious disease[17,22,30,31]
in arthritis[10,19,26,29]
in hepatic disease[2,3,4,5,28]
in malabsorption syndrome[1,2,4,27]
in degenerative disease[6,7,19,23,40]
in cardiac disease[23,28,29,38,41]
in dermatitis[24,39]
in peptic ulcer[8,21,36]
in neuroses & psychiatric disorders[25,26]
in diabetes mellitus[21,22,33,35]
in alcoholism[9,11,35,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[13,19,32]
in pancreatitis[15]
in female climacteric[12,34]

Patients with chronic disease deserve the nutritional support provided by

Theragran-M

Squibb Vitamin-Minerals for Therapy

11 vitamins, 8 minerals clinically-formulated and potency protected to provide enough nutritional support to do some good

with vitamins only
Theragran

also available:
Theragran Liquid
Theragran Junior

1-41 a list of the above references will be supplied on request.

SQUIBB

"THERAGRAN"® IS A SQUIBB TRADEMARK

Squibb Quality—the Priceless Ingredient

Organization cont. from page 79

been concluded and declared the House of Delegates adjourned without day.

The above abstract of minutes of the House of Delegates is respectfully submitted to the Colorado State Medical Society.

HARVEY T. SETHMAN,
Executive Secretary.

1960 Pediatric Round-up

The 50th anniversary of Children's Hospital in Denver, Colorado, being celebrated during 1960, will be marked by an expanded summer clinic, known this year as the "1960 Pediatric Roundup." The "Roundup" program is carried elsewhere in the Journal in an advertisement.

The clinic will present a general type meeting attempting to cover recent advances in pediatrics as well as review important subjects. A slate of nationally recognized authorities heads the speakers list.

Sufficient time is being reserved from the scientific program to allow time for family recreational activities in the vast Granby Recreational Area.

For further information, write Children's Hospital—1960 Pediatric Roundup, 19th and Downing, Denver 18, Colorado.

Obituaries

Denver practitioner dies suddenly

Wenzel Friesch, M.D., of Denver, passed away on April 2, 1960. Dr. Friesch was born in Hungary on March 8, 1900, and came to the United States with his family at the age of seven. The family lived in Springfield, Missouri, and then settled in Pueblo, Colorado.

Dr. Friesch was graduated from Centennial High School in Pueblo and then graduated from the University of Colorado and the Colorado School of Medicine where he was made a member of Phi Beta Kappa honorary fraternity. He was licensed in Colorado in 1927. Dr. Friesch was active in the Lakewood and Denver Country Clubs and was a member of the staff of St. Luke's Hospital.

Survivors are his wife and a sister.

Pueblo octogenarian passes away

Jahleel H. Woodbridge, M.D., of Pueblo, died on March 6, 1960. Dr. Woodbridge was born in Marshall, Missouri, and graduated from the University of Missouri.

Dr. Woodbridge has been one of the oldest practitioners in Pueblo County and specialized in pediatrics. In 1956, the Colorado State Medical Society honored him by electing him to life emeritus membership.

MONTANA

Proceedings of the House of Delegates Montana Medical Association

Thirteenth Interim Session
February 26-27, 1960
Helena

FIRST SESSION

February 26, 1960

The first session of the 13th Interim Session of the House of Delegates of the Montana Medical Association was called to order by Leonard W. Brewer, M.D., President, at 8:45 a.m., February 26, at the Western Life Insurance Company Building, Helena.

The Secretary, William E. Harris, M.D., announced that all delegates seated had presented proper credentials and that a quorum was present.

It was regularly moved, seconded and carried that the following members of this Association be seated as delegates to represent the component society indicated: Edward J. Purdey, M.D., Gallatin County Medical Society; Volney W. Steele, M.D., Gallatin County Medical Society; Albert L. Vadheim, Jr., M.D., Gallatin County Medical Society; Thomas F. Walker, Jr., M.D., Cascade County Medical Society; and David T. Berg, M.D., Lewis and Clark Medical Society.

It was regularly moved, seconded and carried that the minutes of the 81st Annual Meeting be approved as published in the December, 1959, issue of the Rocky Mountain Medical Journal.

Paul J. Gans, M.D., Delegate to the American Medical Association, read an excellent report upon the numerous actions of the House of Delegates of the American Medical Association at its 13th Clinical Meeting in Dallas, December 1-4, 1959. This report of the Delegate was referred by President Brewer to the Reference Committee on Officers, Meetings and Administration for study.

Report of Secretary-Treasurer

William E. Harris, M.D., read the following report of the Secretary-Treasurer which was referred by President Brewer to the Reference Committee on Officers, Meetings and Administration for study:

This has been a rather busy and active period for your Secretary-Treasurer since the annual meeting in Butte. I attended the component medical society meetings in Helena and Anaconda and spoke upon the Forand Bill. They were both well attended. In December, I attended the American Medical Association Clinical Session in Dallas, Texas. It was conducted in its usual well-functioning manner. The opening sessions were highlighted with speeches by Senator Lyndon Johnson and Representative Sam Rayburn. Both men are conservative Democrats and champions of the people. The meeting was well attended and no new astounding medical legislation was instituted. At that time, little mention was made of the Forand Bill.

Early in February, I attended the Blue Shield Professional Relations meeting in Chicago. One of the most interesting speeches was given by Dr. Schwartz, a psychologist from Boston, on the popularity of Blue Shield. Over 90 per cent of the Blue Shield subscribers were satisfied with their policies. Another interesting fact that was brought out was that most patients feel their own doctor made just the right amount of money and that other doctors made too much. Another interesting fact related to me was that the Minnesota Blue Cross and Blue Shield separated as of January 1, 1960.

Your Secretary-Treasurer seriously considered filing for U. S. Representative from the Eastern District, but after reflection and interviews, it would be very difficult for an active practicing physician to gain much momentum in either party or get any concerted support from the medical group. It is a curious fact to me that people as a whole do not feel doctors are rounded out individuals as far as our social welfare is concerned.

As Treasurer of your Association, I would like to submit the following condensed report of income and expenses during 1959:

Income:		
Membership dues	$29,603.75	
Interest on bonds and savings account	676.04	
Income from the sale of exhibit space at annual meeting (net)	3,064.25	
Miscellaneous income (rental and reimbursement for supplies from Montana State Dental Association; sale of insurance forms and fee schedules; allowance for administration of group life insurance plan; 1 per cent rebate for collection of A.M.A. dues, etc.)	1,577.23	
TOTAL		$34,921.27
Expenses:		
Office supplies, including salaries, stationery, postage, rent, telephone, etc.	$17,889.68	
Expenses of officers, committees, delegates, alternate delegates, and executive secretary	4,354.45	
Expenses of annual and interim meetings	3,533.14	
Subscriptions to Rocky Mountain Medical Journal for members	1,300.00	
Memberships in Public Health League of Montana	1,560.00	
Expenses for legal counsel, legislative counsel, and auditors	1,506.71	
Contribution to budget of Woman's Auxiliary	1,872.50	
Taxes	321.97	
Dues and contributions to other groups	295.00	
Miscellaneous expense	457.27	
Expenditures for equipment	148.00	
TOTAL		33,238.72
Excess of income over expenses		$ 1,682.55

On December 31, 1959, there was a balance in the savings account of the Association of $9,318.07, and, in addition, funds with a maturity value of $15,000.00 were invested in government bonds.

During 1959, 557 Montana physicians were active dues-paying members of the Association. This is a slight increase over the number of active dues-paying members during 1958 when the membership totaled 544.

In conclusion, again, I would like to thank Russ Hegland on my own behalf and that of Montana Medical Association for his usual hard work, persistence, and perfection.

Executive Committee report

The Secretary-Treasurer, William E. Harris, M.D., read the following report of the Executive Committee which was referred by President Brewer to the Reference Committee on Officers, Meetings and Administration for study:

Since the annual meeting of your Association in Billings last September, the Executive Committee has met to discuss and transact business of the Association, ad interim, on two occasions. The following report includes a summary of the

business transacted by the committee at meetings during October, 1959, and during January, 1960.

Under the direction of the Executive Committee, the Executive Office of your Association has concluded most of the directives of the House of Delegates following its 1959 annual meeting.

Perhaps the most important problem confronting the profession at the present time is national legislation and the threat of socialization of medicine as proposed under the Forand Bill, H.R. 4700. Early in October, 1959, the Council on Legislative Activities of the American Medical Association invited representatives of each state medical association to a special meeting in St. Louis. The purpose of this meeting was to alert all medical associations to the dangers of the Forand Bill and to plan and initiate a campaign of opposition to the passage of this measure. Following this meeting of the Council on Legislative Activities of the A.M.A., your Executive Committee met to plan the campaign against this measure in Montana. A member of the Executive Committee, during November and December, visited each component society of this Association at a regular monthly meeting, and discussed the Forand Bill with its membership. In addition to the discussion of the Forand Bill at each of these meetings, physicians were encouraged to participate actively in politics, to become members of the political party of their choice, to contribute financially to their political party and to individual candidates, and to influence, whenever possible, not only party policy, but also the selection of candidates for political office. Each component society of the Association was requested to appoint an active legislative committee to cooperate with the Legislative Committee of this Association and to conduct the campaign of opposition to the Forand Bill as suggested and outlined by the American Medical Association. Reports of the activities of the legislative committees of the various component societies indicate that these committees have been active during the past few months and that an effective campaign is under way in each area.

The Forand Bill is still, and will continue to be, a positive threat during the current session of Congress. The passage of this bill, in its present form or in any amended form, will be the opening wedge to a compulsory national health care program. It is reported that proponents of this measure have gained considerable support in Congress to expand the Social Security system to include medical and health care benefits for Social Security beneficiaries. Some sources also report that a few southern Democrats and conservative Republicans are now leaning toward legislation of this type. These reports have special significance during this presidential election year because, historically, Congress has increased and expanded Social Security benefits during the election years. Medicine's campaign of opposition to the Forand Bill must be intensified, and the support of as many nonmedical groups as possible enlisted. Each physician in Montana must assume the responsibility of encouraging a minimum of ten nonmedical persons to write to their Congressmen in opposition to Forand-type legislation. Each Montana physician must also assume the responsibility of encouraging other societies, associations, and groups of which he is a member to adopt resolutions and to write letters opposing passage of this type of legislation. The next three months will be, without doubt, critical months.

In view of the report of the President of the State Board of Medical Examiners at the last annual meeting, your Executive Committee, at each of its meetings, has considered and discussed both the Medical Practice Act of Montana and the Thompson Act. Study of these Montana statutes, however, by your Executive Committee and by the legal counsel of the Association has not yet been completed and your committee, therefore, is not, as yet, prepared to submit recommendations upon these statutes to this House of Delegates.

Your Executive Committee is of the opinion that there is a positive need to improve the relations of physicians with those concerned with the administration of hospitals as well as a need to acquaint the professional and administrative staffs of hospitals of the responsibilities and duties of each. Your Executive Committee recommends to the House of Delegates that it authorize and direct the Hospital Relations Committee to organize a conference of hospital staff officers, administrators, and others interested in hospitals, and that this conference be held during the current year for the discussion of these related mutual problems.

At its January meeting, the Executive Committee studied and reviewed the audit of the books of account of the Association. This report of the auditor indicated that the books of account were in order and that all funds received and disbursed by the Association were properly recorded in its financial records. A copy of the audit of the books of account for 1959 is available through the Secretary for perusal and study of any member of this House of Delegates.

At its January meeting, the Executive Committee carefully studied and reviewed a proposed budget, prepared and submitted by the Treasurer, of anticipated income and expenses for the year 1960. The budget, as finally approved by the Executive Committee, anticipates an income during the current year of $40,800.00, and expenses of $38,448.00. If these estimates of income and expenses prove approximately correct, the operations of your Association during 1960 will result in an estimated surplus of approximately $2,300.00. This surplus is subject to a contingent liability of $1,000.00, however, because payment for compiling and editing the manuscript of the history of medicine in Montana may be requested at any time.

The following supplemental report of the Executive Committee was then read by Secretary Harris. This supplemental report was referred by President Brewer to the Reference Committee on Officers, Meetings and Administration:

Your Executive Committee met again on February 25 and, as a result, wishes to submit a brief supplemental report.

Your Executive Committee has continued study and consideration of the Medical Practice Act of Montana. In addition, it has conferred with the Secretary of the Board, and corresponded and visited with representatives of the legal staff of the A.M.A. to discuss the various sections of this act. The Executive Committee recognizes that the responsibility for any proposed changes in the act rests with the State Board of Medical Examiners and your Executive Committee will cooperate with the board to whatever extent it desires.

Your committee would also like to report that it has voted to cooperate with the Montana Taxpayers' Association and 14 other associations to sponsor a conference on government. This conference will be held in Great Falls on April 8, and your Executive Committee urges physicians throughout the state to plan to attend it. The conference will be informative and will discuss state taxation and spending as well as the creation of a better business climate for Montana.

Robert H. Leeds, M.D., President, Montana Physicians' Service, then presented an excellent report upon the activities of M.P.S. during the past six months, and of its aims and objectives during the coming months. This report was referred by President Brewer to the Reference Committee on Affiliated Organizations for study.

Resolutions introduced

Following a call for new business by Dr. Brewer, Thomas L. Hawkins, M.D., introduced a resolution endorsing the use of impartial medical witnesses and pretrial conferences between attorneys in litigation concerned with the practice of medicine. This resolution was referred by President Brewer to the Reference Committee on Legal Affairs and Professional Relations for study.

Thomas L. Hawkins, M.D., introduced a resolution opposing passage of the Forand Bill, H.R. 4700. This resolution was referred by President Brewer to the Reference Committee on Resolutions and New Business for study.

James A. Shown, M.D., on behalf of the Cascade County Medical Society, introduced a resolution authorizing the President of this Association to appoint a committee to investigate the need for the establishment of a poison control center in Montana. This resolution was referred by President Brewer to the Reference Committee on Scientific Work for study.

On behalf of the Cascade County Medical Society, Dr. Shown also introduced a resolution to encourage component medical societies of this Association to participate actively and to cooperate with the various committees organized to study the care and problems of the aged, and to

encourage each component medical society to conduct an educational campaign among the various professional groups to seek a realistic solution to the various problems concerned with the aging population. This resolution was referred by President Brewer to the Reference Committee on Resolutions and New Business for study.

Alfred M. Fulton, M.D., on behalf of the Montana Society for Internal Medicine, introduced a report proposing that the Average Fee Schedule of this Association be amended and revised to include additional procedures characteristic of the practice of internal medicine. This report was referred by President Brewer to the Reference Committee on Legal Affairs and Professional Relations for study.

Morris A. Gold, M.D., read a lengthy communication that had been forwarded to him as Chairman of the Interprofessional Relations Committee of this Association by John G. Stajcar, President of Silver Bow County Pharmaceutical Society. This communication was referred by President Brewer to the Reference Committee on Affiliated Organizations for study.

President Brewer announced that the reports of the various standing and special committees and of the several representatives of this Association to other groups included in the file of each delegate would be considered as business properly introduced to the House of Delegates for consideration, and that these reports were hereby referred to the reference committee indicated in each report for study. President Brewer then called for the introduction of additional resolutions and new business. No additional resolutions or new business, however, were presented for consideration.

President Brewer then announced the various scheduled meetings of the several reference committees of this Association and urged all members to attend those in which they were particularly interested to present their views.

The first session of the House of Delegates recessed at 9:45 a.m.

SECOND SESSION

February 27, 1960

The second session of the 13th Interim Session of the House of Delegates of the Montana Medical Association was called to order by Leonard W. Brewer, M.D., President, at 9:00 a.m. in the Western Life Insurance Company Building, Helena.

Following the roll call, William E. Harris, M.D., Secretary, announced that a quorum was present.

Upon motion regularly seconded and carried, the following members of this Association were seated as delegates to represent the component society indicated: Robert W. Thometz, M.D., Silver Bow County Medical Society; Henry D. Rossiter, M.D., Silver Bow County Medical Society; Richard J. Best, M.D., Silver Bow County Medical Society; Raymond E. Smalley, M.D., Yellowstone Valley Medical Society; Herbert T. Caraway, M.D., Yellowstone Valley Medical Society; Clarence H. Swanson, Jr., M.D., Yellowstone Valley Medical Society; Wyman J. Roberts, M.D., Cascade County Medical Society.

President Brewer called for additional new business but none was presented.

The following report was presented by Joseph S. Pennepacker, M.D., Chairman of the Reference Committee on Officers, Meetings and Administration:

Your Reference Committee on Officers, Meetings and Administration met on February 26 to review and consider the several reports referred to it for study. It submits the following comments and recommendations upon these reports:

Report of the Delegate to the A.M.A.: The members of this reference committee reviewed with interest the report of Paul J. Gans, M.D., the Delegate of this Association to the American Medical Association. It believes that your Association was ably represented at the Clinical Meeting of the American Medical Association in Dallas and wishes to commend Dr. Gans for his excellent report upon the meetings of the House of Delegates of the A.M.A. Inasmuch as the report of the Delegate is informative and does not contain any recommendations, your reference committee is of the opinion that no action upon it is necessary.

Dr. Pennepacker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Report of the Secretary-Treasurer: Your reference committee is very pleased to note that the financial statement included in the report of the Secretary-Treasurer indicates a small excess of income over expenses for the year 1959. Your committee would like to take this opportunity to commend Dr. Harris for his conduct of the office of Secretary-Treasurer and to express its appreciation to the Executive Secretary who has cooperated closely with Dr. Harris. Inasmuch as the report of the Secretary-Treasurer is informative only, your reference committee is of the opinion that no action upon it is necessary.

Dr. Pennepacker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

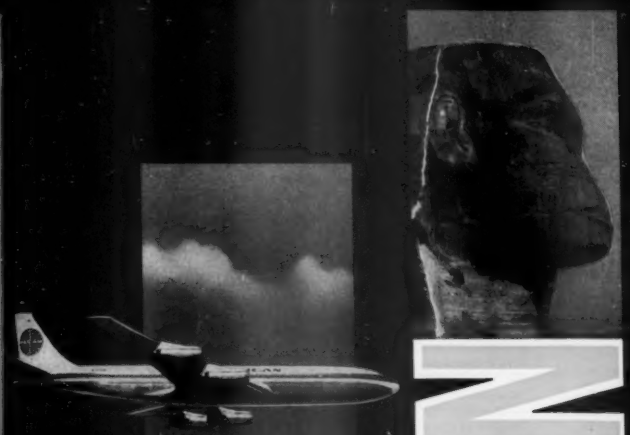
Report of the Executive Committee: Your reference committee has studied with especial care the report of the Executive Committee and urges that it be read and studied by every member of this Association. First, the section of the report of the Executive Committee commenting upon the Forand Bill, H.R. 4700, and Forand-type legislation emphasizes the critical necessity of informing as many citizens as possible about the dangers of this legislation and of urging them actively to oppose its passage. The comments of the Executive Committee upon this proposed legislation are primarily for the information of the House of Delegates but your reference committee commends the sentiments expressed by the Executive Committee and urges that every member of this House review this portion of the report with special care.

Dr. Pennepacker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

In its report to this House, the Executive Committee recommended that this House of Delegates authorize the Hospital Relations Committee of this Association to organize, sponsor, and hold, during 1960, a conference of hospital staff officers, trustees, administrators and others interested in hospitals for the consideration of mutual problems. Relationships between individuals concerned with the operation of hospitals and physicians, as well as the relations between their respective organizations in Montana, have not always been as friendly and cooperative as may be desirable. Your reference committee heartily concurs with this recommendation of the Executive Committee and recommends its approval by this House of Delegates.

Dr. Pennepacker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Your reference committee received testimony from several of the officers of this Association about the comments of the Executive Committee in its supplemental report. In brief,



SPEED DURATION

IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available—for greater flexibility in dosage—PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

Endo

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

*U.S. Pat. 2,628,185

PHOTO BY PAN AMERICAN WORLD AIRWAYS

the Executive Committee reports that the Medical Practice Act of Montana is currently being studied and the necessity for its revision is being considered as the result of the action of the House of Delegates of the American Medical Association under which the Council on Medical Education and Hospitals no longer approves foreign medical schools. Your reference committee approves of the opinion expressed by the Executive Committee and believes that, since the members of the State Board of Medical Examiners will be entrusted with the enforcement of the Medical Practice Act of Montana, they should be the individuals responsible for initiating and outlining any proposed changes in the Act. Your reference committee endorses the statements of the Executive Committee and encourages the Executive Committee to continue its close cooperation with the members of the State Board of Medical Examiners in this endeavor.

Dr. Pennepacker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Your reference committee approves the proposal of the Executive Committee that this Association cooperate with the Montana Taxpayers' Association and 14 other associations in the sponsorship of a conference on government to be held in Great Falls on April 8. It would like to take this opportunity to urge that Montana physicians plan to attend this important conference which will consider state taxation and expenditures. Your reference committee recommends that this House of Delegates approve the participation of the Association in this conference.

Dr. Pennepacker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

The remaining sections of the report of the Executive Committee are not controversial and have been submitted basically for the information of the House of Delegates. Your reference committee is of the opinion that further action upon this report is not necessary, but it would like to express the appreciation of the membership to the Executive Committee for its earnest endeavors and devotion to the activities of the Association, for it is the members of the Executive Committee who directly keep the Association functioning properly and smoothly.

Dr. Pennepacker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried. He then moved the adoption of the report of the Reference Committee on Officers, Meetings and Administration as a whole. This motion was seconded and carried.

The following report was presented by Wyman J. Roberts, M.D., Chairman of the Reference Committee on Legislation and Public Relations:

Only two reports of standing committees were referred to this reference committee for study.

Report of the Rural Health Committee: The Rural Health Committee indicates in its report that it has completed a preliminary draft of the booklet outlining certain facts upon health insurance for the information of Montana citizens who plan to purchase medical and hospital insurance coverage. Since this booklet has not, as yet, been approved by the members of the Committee on Rural Health, it is not available for distribution to the members of this House of Delegates and specific comment upon the booklet, therefore, cannot be submitted to the members of this House at this meeting.

Dr. Roberts moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Report of the Legislative Committee: The Legislative Committee, in its report, recommends that each of the component medical societies of this Association appoint an active and interested committee on legislation and that this committee plan to organize a speakers bureau which will be prepared to address various groups, such as service clubs, women's groups, etc., upon legislation of interest to the medical profession and the citizens of Montana. The Legislative Committee also recommends that these committees, as well as every individual member of this Association, encourage all organized groups to adopt resolutions of opposition to the passage of the Forand Bill and that these committees also encourage their friends to address letters to the Montana Congressmen and to Representative Wilbur D. Mills, Chairman of the Ways and Means Committee of the U. S. House of Representatives, opposing the passage of this legislation. Your reference committee heartily endorses these recommendations of the Legislation Committee and recommends their approval by this House of Delegates.

Dr. Roberts moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried. He then moved the adoption of the report of the Reference Committee on Legislation and Public Relations as a whole. This motion was seconded and carried.

The following report was presented by Richard J. Best, M.D., on behalf of Henry D. Rossiter, M.D., Chairman of the Reference Committee on Legal Affairs and Professional Relations:

Your Reference Committee on Legal Affairs and Professional Relations studied and reviewed reports from the following committees of this Association:

Report of the Committee on Necrology and History of Medicine: The Committee on Necrology and History of Medicine reported the deaths of the following Montana physicians since the last meeting of this Association: Edwin Myron Adams, M.D., Red Lodge, December 4, 1959; John Kennedy Colman, M.D., Butte, December 19, 1959; Maude Marguerite Gerdes, M.D., Miles City, December 27, 1959; Drura R. Claiborn, M.D., Big Timber, December 30, 1959. Montana physicians extend to the family of each of these physicians their sincere sympathy and condolences. It is appropriate at this time that the respect of each member of the medical profession be recorded in the minutes of the meeting of this House of Delegates in recognition of these physicians who have served the people of Montana in their profession with such distinction. (The members of the House of Delegates rose and paused in silence in memory of these physicians.)

Your reference committee notes with interest that the Committee on Necrology and History of Medicine is proceeding with the preparation of the manuscript, "Medicine in

continued on page 93

the Making of Montana," and anticipates that the text of this volume will soon be completed and ready to submit to publishers for bid.

Dr. Best moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Report of the Economic Committee: In its report, the Economic Committee commented upon its study to determine whether or not a welfare plan for indigent physicians and their dependents should be established by this Association. It also reported that its study of the advisability of establishing a pension fund for physicians will be continued and that a report upon this subject will probably be presented at the next annual meeting. Study of the Average Fee Schedule of this Association will be continued by the Economic Committee during the next few months and its recommendations for revision of the schedule, it is anticipated, will be presented to the House of Delegates at the 82nd Annual Meeting. Your reference committee considered the proposal submitted by the Montana Chapter of the Western Orthopedic Association recommending that the Average Fee Schedule of this Association be adopted for all professional work, including that performed by social, public and other official agencies. This principle is endorsed wholeheartedly by the Economic Committee and it is prepared to work toward this desirable goal in every way possible. It is the opinion of your reference committee that one of the basic reasons for the adoption of the Average Fee Schedule was that it may be used as the basis of negotiations in all agreements with public and private agencies for the provision of medical or surgical services. Inasmuch as this principle has already been endorsed by this House of Delegates, it is the opinion of your reference committee that no further action is necessary upon the recommendation of the Economic Committee and, therefore, this reference committee suggests that the report of the Economic Committee be placed on file.

Dr. Best moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Your reference committee has reviewed the report presented by Alfred M. Fulton, M.D., on behalf of the Montana Society of Internal Medicine and is of the opinion that a section on internal medicine may appropriately be incorporated as a special division of the Average Fee Schedule of this Association. Your reference committee recommends that this House of Delegates request the Economic Committee to incorporate this division on internal medicine when it presents its proposals for other changes in the schedule at the annual meeting.

It was moved by Dr. Best and seconded that this portion of the report of the reference committee be adopted. Several delegates, however, requested that the intent of the reference committee upon its recommendation to incorporate a division on internal medicine in the Average Fee Schedule be clarified. Following some discussion of this portion of the report of the reference committee, it was agreed that its recommendation should not be interpreted as a directive to the Economic Committee, but as a request that that committee consider the proposal presented by Dr. Fulton during its study of all other sections of the fee schedule, which study it proposes to complete within the next few months. With this understanding, the motion by Dr. Best was carried.

Report of the Legal Affairs Committee: The Legal Affairs Committee reported that at the present time there are no pending professional liability suits of an imminent or alarming nature. This committee, however, suggests that the entire membership of this Association again review the booklet entitled "Liability" and, further, that each member of the Association accept the duty and responsibility of reporting to the Legal Affairs Committee any threatened or imminent professional liability action against any member of the Association, or any violation of the published rules of the Legal Affairs Committee. In its report, this committee announced that both the Aetna Casualty and Surety Company and the U. S. Fidelity and Guaranty Company have appreciably reduced premiums for professional liability insurance. This welcome information upon the reduction of professional liability premiums is attributed in part to the efforts of the Legal Affairs Committee and in part to other diligent committees of this Association, such as the Mediation Committee. Inasmuch as the report of the Legal Affairs Committee is primarily informative, your reference committee is of the opinion that no action upon it is necessary.

Dr. Best moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Action on resolutions

The following resolution was introduced on the floor of this House of Delegates at its first session by Thomas L. Hawkins, M.D., on behalf of the Lewis and Clark Medical Society:

WHEREAS, Practicing members of the Montana Medical Association have been embarrassed when they appear in court on litigation in personal injury suits; and

WHEREAS, Doctors of medicine attempt in all cases to present to the court the full findings made in an examination of the patient and only wish to present what, in their professional opinion, are the facts in the case; and

WHEREAS, The doctor, when appearing for or against the litigant, finds himself in a state of advocacy; and

WHEREAS, He is constantly disturbed by the counsel on the opposing side and attempt is made to destroy his testimony; and

WHEREAS, The Montana Medical Association is in full accord with the court system of advocacy, yet there is a very disturbing conflict between the findings presented by the doctor on either side and the system of advocacy which is practiced by the attorney; and

WHEREAS, There appears to be a relief from this situation for the doctor of medicine through the use of impartial medical witnesses and pretrial conferences of the court; therefore, be it

RESOLVED, That the Montana Medical Association endorses the proceedings of impartial medical witnesses and pretrial conferences in litigation involving doctors of medicine and realizes fully that the implementing of these proceedings must be made by the courts and the Montana Bar Association; the Montana Medical Association wishes to inform the courts and the Montana Bar Association of its wish to cooperate in every manner with inaugurating of these proceedings.

Your reference committee is of the opinion that **action** upon the above resolution is **unnecessary** at this time since this House of Delegtaes, during its 12th Interim Session, voted to authorize the Legal Affairs Committee to draft the necessary legislation to provide impartial medical witnesses and pretrial conferences in all litigation involving physicians. Your reference committee, however, believes that it is appropriate for this House to reaffirm its previous action and so recommends to this House.

Dr. Best moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried. He then moved the adoption of the report of the Reference Committee on Legal Affairs and Professional Relations as a whole. This motion was seconded and carried.

The following report was presented by George M. Donich, M.D., Chairman of the Reference Committee on Resolutions and New Business:

The Reference Committee on Resolutions and New Business reviewed with interest the several resolutions submitted to it for consideration. The following resolution was presented on the floor of this House of Delegates at its first session on behalf of the Cascade County Medical Society:

WHEREAS, The physicians of Cascade County are unanimously opposed to any form of government control over the private practice of medicine, and are fully convinced that the Forand Bill, or any other similar type of federal legislation, is financially unsound, unrealistic, and premature for the following reasons:

(1) The care of the needy and aged can be more realistically and satisfactorily handled on a local level;

(2) It will destroy and nullify gains which are being made in the field of private health insurance programs;

(3) The cost added to the already burdensome welfare program will be staggering and may be almost prohibitive;

(4) It will hinder medical research and destroy individual initiative and incentive;

(5) The Forand Bill and similar legislation will force a type of government-controlled medicine on a large number of people who are not in need of it, do not desire it, and should not be forced to pay for it; therefore, be it

RESOLVED, That the House of Delegates of the Montana Medical Association encourage its component medical societies to participate more freely in the various committees which have been organized by the Montana Medical Association for the study of the care and problems of the aged; and be it

RESOLVED further, That this House of Delegates request each component medical society to conduct an educational campaign among the allied professions of dentistry, pharmacy, nursing, and law, and among business and trade groups, by calling together the leaders in these organizations for the purpose of developing a realistic answer to federal medical legislation.

Your reference committee recommends the **adoption** of this resolution by this House of Delegates.

Dr. Donich moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

The following resolution expressing the opposition of the members of this Association to the Forand Bill, H.R. 4700, and to Forand-type legislation, was also presented on the floor of this House of Delegates at its first session:

WHEREAS, There is now in the Ways and Means Committee of the House of Representatives, H.R. 4700, commonly called the Forand Bill, an amendment to the Social Security Act, to provide hospital and nursing home and surgical care to retired indivduals on Social Security benefits; and

WHEREAS, This innocuous appearing amendment is in reality the missile head of the complete socialization of medicine for all persons in the United States; and

WHEREAS, The coverage of 12 to 15 million retired individuals by taxes not contributed by them, but paid by present and future wage earners, is in no way fair, honorable, or honest to present contributors, and is initiated without their consent; and

WHEREAS, There is no information that retired individuals wish to accept the charity of present and future wage earners but contrarily there are thousands of retired Social Security recipients who reject being unable to make their choice of medical and hospital management; and

WHEREAS, The enactment of laws regulating the lives of large segments of citizens, without their consent, contravenes all of the Articles of the Constitution and the Bill of Rights, and expressly denies the rights of the minority; and

WHEREAS, By no stretch of the imagination can such legislation be considered to be for the benefit of the Public Welfare, since the very tenets of this legislation are based on confiscation of individual funds; and

WHEREAS, The enactment of a law by Congress does not convert wrong into right; and

WHEREAS, The enactment of this amendment is tainted with partisan political flavor devised in a political election year and used as a vehicle to manipulate the savings of the present wage earner for the interest of the political power of the party; and

WHEREAS, Since the defeat of the Wagner-Murray-Dingell Bill, over 130 million individuals have voluntarily chosen to insure themselves against sickness costs, during which period the American public has enjoyed the lowest death rate and the longest extension of life known in history; and

WHEREAS, The greatest contribution to human welfare has been made by advances in medicine under the present system of free choice of physician, hospital, and medical care; and

WHEREAS, The success of the present system is sufficient evidence that it will continue to progress in the care of all segments of the population and that the death rate will continue to fall, the incidence of illness will decrease, and there will be continued increased healthful longevity; and

WHEREAS, There is overwhelming proof of the deca-

dence of medicine in socialized states in contrast to the American system; therefore, be it

RESOLVED, That Montana Medical Association express its unalterable opposition to the Forand Bill, the Kennedy Bill, or any other bill which would bind the hands, regulate the minds, and destroy the initiative and the enthusiasm of the practitioner of medicine to do his utmost in the care of his patient; and be it

RESOLVED further, That a benevolent Creator will so guide the Congress of the United States that it will not destroy a system of medical practice so eminently successful and with such a brilliant future and, above all, that Congress will keep its faith with the people, preserve and protect their rights, and continue to honorably represent the people first and always, and incidentally be politically partisan.

Your reference committee heartily concurs with the principles expressed in this resolution and recommends its adoption by this House of Delegates.

Dr. Donich moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried unanimously.

Following adoption of this resolution, it was regularly moved, seconded and carried that the Secretary be instructed to forward a copy of the resolution to the members of Congress from Montana and to Honorable Wilbur D. Mills, Chairman of the Ways and Means Committee of the U. S. House of Representatives.

Your reference committee also recommends that this House of Delegates instruct the Secretary to write appropriate letters of appreciation to all of the individuals and organizations that contributed to the success of this 13th Interim Session.

Dr. Donich moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried. He then moved the adoption of the report of the Reference Committee on Resolutions and New Business as a whole. This motion was seconded and carried.

The following report was presented by John R. Burgess, M.D., Chairman of the Reference Committee on Affiliated Organizations:

Your Reference Committee on Affiliated Organizations carefully considered the various reports submitted to it. It should be noted that all of these reports have been submitted by representatives of this Association to various voluntary health groups and that these reports are not, therefore, reports of standing committees of this Association, per se. All of these groups are lay groups and our representatives are merely reporting on their activities. The following organizations have not scheduled meetings since the last session of this House of Delegates and, hence, no report of their activities is forthcoming: Montana Committee for the Employment of the Physically Handicapped; American Medical Education Foundation; Advisory Committee on Narcotic and Alcohol Education; State Board of Medical Examiners; Committee of the Health Insurance Council; Managing Editor of the Rocky Mountain Medical Journal.

Public Health League

The report of the activities of the Public Health League of Montana was submitted by Everett H. Lindstrom, M.D., who is currently serving as President of this organization. He reports that aggressive action has been taken by the League in opposition to passage of the Forand Bill, and that during 1959, no legislation was enacted by the Legislative Assembly that was detrimental to the high standards of medical practice and medical care. Dr. Lindstrom, in his report, also announced the resignation of Mr. Duane W. Bowler as manager of the Public Health League. Mr. Bowler, at the time of his resignation, proposed that the official publication of the League, "Montana Health," be mailed to each of the beneficiary members of Blue Shield. Our representative to the League, Dr. Lindstrom, reports that this suggestion is worthy of serious consideration by this House of Delegates. Your reference committee is of the opinion that the Public Health League of Montana should be congratulated for its vigilance and active role in upholding the high standards of medical care and practice in Montana.

Dr. Burgess moved the adoption of this portion of the report of the reference committee. During the discussion of this report of the reference committee, President Brewer commended Mr. Bowler for his efficient management of the Public Health League of Montana and suggested that the House of Delegates discuss the activities of the League, as well as the value of its aims and objectives to the medical profession. Several members of the House of Delegates expressed such opinions, but no action was taken. It was also pointed out during the discussion of this portion of the report of the reference committee that the suggestion concerning subscriptions to "Montana Health" by Blue Shield beneficiary members should be considered merely as a request that the Board of Trustees of Montana Physicians' Service consider such a group subscription since this House of Delegates does not have the authority to act upon this proposal. Following this discussion, the original motion by Dr. Burgess was voted upon and carried.

Walter G. Tanglin, M.D., representative of this Association to the Montana Health Planning Council, reported that several excellent addresses had been presented by Montana physicians at the several recent meetings of the Council. He also expressed the opinion that the valuable information included in these addresses does not receive as wide a distribution as it should and that, therefore, these addresses, or at least portions of them, should be published in the Bulletin of this Association. The Executive Secretary has advised your reference committee that excerpts from these addresses may appropriately be published in the Bulletin and that their publication is already planned. Your reference committee wishes to commend the Montana Health Planning Council upon its

achievements, as well as Dr. Tanglin for the very fine report that he has submitted to this House of Delegates.

Dr. Burgess moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

The report of the President of Montana Physicians' Service, Robert H. Leeds, M.D., was read to this House during its first session. Dr. Leeds, in his report, again emphasized the importance of the role of Montana Physicians' Service in providing medical and hospital insurance coverage to citizens 65 years of age and older at a cost which may be afforded by this segment of our society. This health protection plan is the strongest weapon of the medical profession in combating federal aid to our aging population. With consideration of the Forand Bill imminent, the wholehearted support of the medical profession for the Blue plans is of vast importance and will, without doubt, contribute much to the defeat of the legislation of this type. Dr. Leeds also reported upon the increase in the beneficiary membership of Blue Shield and upon its success in the conversion of group memberships which have resulted in an increase in the amounts paid to physicians for medical and surgical services to beneficiary members. He also pointed out that the series "65" coverage will continue under the old contracts of Montana Physicians' Service and payments for medical and surgical services will be continued under the previous schedule of benefits. Financially, Montana Physicians' Service has had another successful year and, with its continued growth and acceptance, this reference committee is of the opinion that its officers and staff should be heartily congratulated for their services, both to beneficiary and professional members.

After reviewing the lengthy correspondence from the Silver Bow Pharmaceutical Association which was read on the floor of this House of Delegates by Morris A. Gold, M.D., and after hearing the testimony and explanations of officers and members of the Board of Trustees of Montana Physicians' Service and other interested parties, it is the opinion of this reference committee that (1) financial disagreements between Montana Physicians' Service and members of the pharmaceutical societies may best be settled by peaceful negotiations between representatives of each group; and (2) that the question of legend prescriptions should be clarified by the Board of Trustees of Montana Physicians' Service. Your reference committee recommends the approval of these opinions and suggests that they be transmitted to the Board of Trustees of Montana Physicians' Service.

Dr. Burgess moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

The representative of your Association to the Advisory Committee for Practical Nursing, Deane C. Epler, M.D., reported upon the activities of this committee after his attendance at its meeting on January 20. Dr. Epler, in his report, states that the meeting was primarily concerned with the present facilities for the training of practical nurses and with the possibility of forming additional schools for the training of practical nurses. He states in his report that of the 530 licensed practical nurses in Montana, only 70 have graduated from practical nursing training schools. Dr. Epler recommends that the Montana Medical Association stimulate the establishment and promotion of schools for practical nursing in the larger centers of Montana. Your reference committee concurs with this recommendation and suggests its approval by this House of Delegates.

Dr. Burgess moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried. He then moved the adoption of the report of the Reference Committee on Affiliated Organizations as a whole. This motion was seconded and carried.

Herbert T. Caraway, M.D., then moved that the Secretary of this Association be instructed to write Mr. Duane W. Bowler to express the thanks and appreciation of the Association and of the medical profession for his many valuable services to the medical profession as manager of the Public Health League of Montana, and to extend the best wishes of this House of Delegates for his continued success. This motion was seconded and carried unanimously.

Additional reports approved

The following report was presented by Harold A. Braun, M.D., Chairman of the Reference Committee on Health and Well-Being:

Report of the Committee on Aging: Your Reference Committee on Health and Well-Being reviewed with interest the report of the Chairman of the Committee on Aging of this Association and observed with appreciation the continued dedicated work of the chairman of this committee. The report of this committee includes a summary of certain plans of the Governor's Committee on Aging about which members of this House of Delegates should be fully informed. First, the Chairman of the Governor's Committee on Aging plans to appoint seven fact-finding subcommittees. It is anticipated that a member of this Association will be invited to serve on each of these subcommittees and your reference committee recommends that those physicians who are requested to serve should accept promptly and participate actively. It is also planned that questionnaires about the problems of the aging population will be distributed by these subcommittees to members of the Montana Hospital Association and to physicians. Each individual and group is urged to provide the information requested on these questionnaires thoughtfully and to return them promptly. Your reference committee heartily endorses the recommendations of the Committee on Aging that the active participation of all physicians is necessary and urges that each component medical society of this Association which has not already done so immediately appoint a committee on aging and that these committees in all component medical societies, in cooperation with the Committee on Aging of this Association, complete their assigned tasks as promptly and as efficiently as possible.

Dr. Braun moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

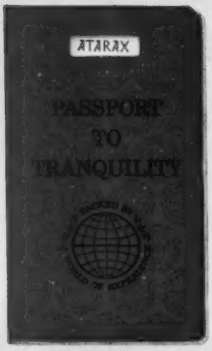
Report of the Emergency Medical Service Committee: This reference committee reviewed the report of the Chairman of the Emergency Medical Service Committee carefully. It sincerely regrets that W. Bruce Talbot, M.D., of Butte, has resigned as a member of the Emergency Medical Service Committee because he has accepted a position in another state, but wishes to extend the appreciation of Montana physicians to him for his active service and participation as a member of this committee. Inasmuch as the report of this committee is informative, your reference committee is of the opinion that no action upon it is necessary.

Dr. Braun moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

"Who needs a baby formula? We just had one without it."

A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. 10:164, 1956. Ayd, F. J., Jr.: California Med. 87:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. 112:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics 11:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better ... and led a more normal life.... In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. 50:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

Rx PFIZER

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

Report of the Committee on Highway Safety: Your reference committee has studied the report of the Committee on Highway Safety and observed that it contains the following two proposals to decrease the alarming number of traffic deaths on the highways of Montana: (1) That the House of Delegates of this Association consider the adoption of a resolution urging that the Legislative Assembly, during its 1961 session, enact a daytime speed limit of 65 to 75 miles per hour with radar control; and (2) that the Montana Highway Patrol be empowered to employ an individual to conduct, under the direction of its supervisor, an effective educational campaign to promote traffic safety. Your reference committee is of the opinion that these proposals are worthwhile and recommends their approval by this House of Delegates.

It was moved by Dr. Braun and seconded that this portion of the report of the reference committee be adopted. During the discussion of this motion, several members of the House of Delegates suggested that the establishment of a speed limit did not necessarily result in a reduction of traffic deaths since many other factors seem to be responsible for the increasing toll on Montana highways. It was then regularly moved, seconded and carried that this portion of the report of the reference committee be tabled. William E. Harris, M.D., then moved that the House of Delegates reaffirm the action taken at the 81st Annual Meeting of this Association in Butte upon highway safety. This action was as follows: (1) That the number of highway patrolmen be greatly increased; (2) that the nighttime speed limit and the regulations pertaining to reckless driving and careless driving be more strictly enforced; and (3) that the Legislative Assembly of Montana enact, during its next session, a law to limit the daytime speed on the highways of Montana. This motion was seconded and carried.

Dr. Braun then moved the adoption of the report of the Reference Committee on Health and Well-Being, as amended, as a whole. This motion was seconded and carried.

The following report was presented by Thomas F. Walker, Jr., M.D., Chairman of the Reference Committee on Scientific Work:

The Reference Committee on Scientific Work reviewed and considered the four reports that were referred to it for study.

Report of the Committee on Mental Hygiene: The report of this committee indicates that it is continuing its efforts to draft, in cooperation with a number of interested groups, legislation concerning the hospitalization of the mentally ill patient. It is anticipated by the committee that its recommendations for the amendment of Montana statutes relating to mentally ill patients will be completed during the next few months so that they may be presented to this House of Delegates for action at the 82nd Annual Meeting. Inasmuch as the report of the Committee on Mental Hygiene is informative and contains no recommendations, your reference committee is of the opinion that no action upon it is necessary at this time.

Dr. Walker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Report of the Rheumatic Fever and Heart Committee: The Chairman of this committee, John S. Gilson, M.D., has submitted a comprehensive report outlining the present status of the rheumatic fever prophylaxis program. Your reference committee is of the opinion that this report should be carefully studied by all members of the Association so that they will be familiar with this important project. Inasmuch as the report of the Rheumatic Fever and Heart Committee is informative and contains no recommendations, your reference committee is of the opinion that no action upon it is necessary at this time.

Dr. Walker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

At the first session of this House of Delegates, the following resolution was introduced by representatives of the Cascade County Medical Society:

WHEREAS, There has been great increase in poisonous and noxious substances obtainable by the citizens of Montana; and

WHEREAS, The expense of equipping each hospital and/or physician with complete poison control information is almost prohibitive; therefore, be it

RESOLVED, That the President of the Montana Medical Association be authorized to appoint a special committee, or to request one of the standing committees of this Association, to investigate the necessity and the means of establishing a poison control center or centers within the State of Montana.

Your reference committee recommends the **adoption** of this resolution by the House of Delegates.

Dr. Walker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried.

Report of the Subcommittee on Obstetrics: The Chairman of the Subcommittee on Obstetrics, in his report to this House of Delegates, recommended that each Montana hospital consider every hospital chart of a maternal or newborn mortality incomplete until the information requested on the questionnaires distributed by this subcommittee has been provided and that each hospital in Montana assume the responsibility of forwarding the completed questionnaire to the State Board of Health. Your reference committee is of the opinion that this recommendation should not be adopted because few, if any, hospitals in Montana will undertake this additional responsibility because it is the responsibility of the physician concerned to furnish the information requested on the questionnaire, and because this procedure will, in the opinion of this reference committee, actually not improve the number of responses received or the quality of the information provided in the questionnaire.

Dr. Walker moved the adoption of this portion of the report of the reference committee. This motion was seconded and carried. He then moved the adoption of the report of the Reference Committee on Scientific Work as a whole. This motion was seconded and carried.

President Brewer then introduced Frank L. McPhail, M.D., a member of the Western Interstate Commission for Higher Education, and requested that he address the House and inform it upon the activities of this commission. Dr. McPhail, in his address, reported upon the future medical manpower needs, not only in Montana, but in other western states, and predicted that within the next 12 to 15 years, most of the western states will experience a shortage of physicians and other professional personnel. He suggested that this House of Delegates consider ways and means to further analyze this problem in Montana and that this Association, perhaps in cooperation with the medical associations in adjoining states, contemplate and consider the advisability of establishing a regional medical school. Following a discussion of the proposals of Dr. McPhail, it was moved by Herbert T. Caraway, M.D., that President Brewer be authorized to appoint an energetic committee to investigate the several proposals and possibilities suggested by Dr. McPhail in his address. This motion was seconded and carried.

There being no further business, the House of Delegates adjourned sine die at 11:45 a.m.

The following delegates and alternate delegates attended these sessions of the House of Delegates:

CASCADE COUNTY MEDICAL SOCIETY: Paul R. Ensign, M.D., Great Falls; Harold W. Fuller, M.D., Great Falls; Arthur K. Northrop, M.D., Great Falls; Arnold E. Ritt, M.D., Great

Falls; Wyman J. Roberts, M.D., Great Falls; James A. Shown, M.D., Great Falls; Charles H. Steele, M.D., Great Falls; Thomas F. Walker, Jr., M.D., Great Falls.

FERGUS COUNTY MEDICAL SOCIETY: Paul J. Gans, M.D., Lewistown; John W. Schubert, M.D., Lewistown.

FLATHEAD COUNTY MEDICAL SOCIETY: Clyde H. Fredrickson, M.D., Kalispell; J. Jerome Wildgen, M.D., Kalispell.

GALLATIN COUNTY MEDICAL SOCIETY: Edward J. Purdey, M.D., Bozeman; Volney W. Steele, M.D., Bozeman; Albert L. Vadheim, Jr., M.D., Bozeman.

HILL COUNTY MEDICAL SOCIETY: Norman A. Franken, M.D., Havre; Chester W. Lawson, M.D., Havre; Robert H. Leeds, M.D., Chinook.

LEWIS AND CLARK MEDICAL SOCIETY: Orville J. Andersen, M.D., Fort Harrison; David T. Berg, M.D., Helena; John R. Burgess, Jr., M.D., Helena; David P. Findley, M.D., Helena; Raymond O. Lewis, M.D., Helena; Edward C. Maronick, M.D., Helena; Frank P. Nash, M.D., Townsend; G. D. Carlyle Thompson, M.D., Helena.

MOUNT POWELL MEDICAL SOCIETY: George M. Donich, M.D., Anaconda; George E. Trobough, M.D., Anaconda; Mabel E. Tuchscherer, M.D., Anaconda.

NORTHCENTRAL MONTANA MEDICAL SOCIETY: Edward L. King, M.D., Browning; Robert F. Stanchfield, M.D., Shelby.

NORTHEASTERN MONTANA MEDICAL SOCIETY: Mark B. Listerud, M.D., Wolf Point.

PARK-SWEETGRASS MEDICAL SOCIETY: William E. Harris, M.D., Livingston.

SILVER BOW COUNTY MEDICAL SOCIETY: Richard J. Best, M.D., Butte; Morris A. Gold, M.D., Butte; Raymond F. Peterson, M.D., Butte; Henry D. Rossiter, M.D., Sheridan; Robert W. Thometz, M.D., Butte.

SOUTHEASTERN MONTANA MEDICAL SOCIETY: Joseph S. Pennepacker, M.D., Sidney; Sidney C. Pratt, M.D., Miles City; James R. Thompson, M.D., Miles City.

WESTERN MONTANA MEDICAL SOCIETY: Harold A. Braun, M.D., Missoula; Gerald A. Diettert, M.D., Missoula; John A. Evert, M.D., Missoula; Leonard E. Kuffel, M.D., Missoula; William J. McDonald, M.D., Missoula; John E. Minckler, M.D., Missoula; John M. Nelson, M.D., Missoula.

YELLOWSTONE VALLEY MEDICAL SOCIETY: Carl H. H. Baumann, M.D., Billings; Herbert T. Caraway, M.D., Billings; Alfred M. Fulton, M.D., Billings; Raymond E. Smalley, M.D., Billings; Clarence H. Swanson, Jr., M.D., Columbus.

Golf tournament

Golf minded physicians attending the A.M.A. meeting in Miami Beach will be offered an opportunity to play one of the finest 18-hole championship courses in the country, according to the President of the American Medical Golf Association. Their 44th annual tournament will be held at the Diplomat Country Club in Hollywood, Florida, on Monday, June 13.

Tee off has been scheduled for 8:00 a.m. through 2:00 p.m. on Monday, June 13. In the late afternoon, professional exhibitions will be scheduled to give pointers and help to AMGA members. The cocktail hour will be from 6:00 p.m. to 7:00 p.m. and will be followed by the annual banquet and meeting. Prizes for tournament play will be awarded after the banquet.

Members of the American Medical Association who do not hold membership in the American Medical Golf Association should contact Dr. John A. Growdon, 1324 Professional Building, Kansas City, Missouri, to secure an application form.

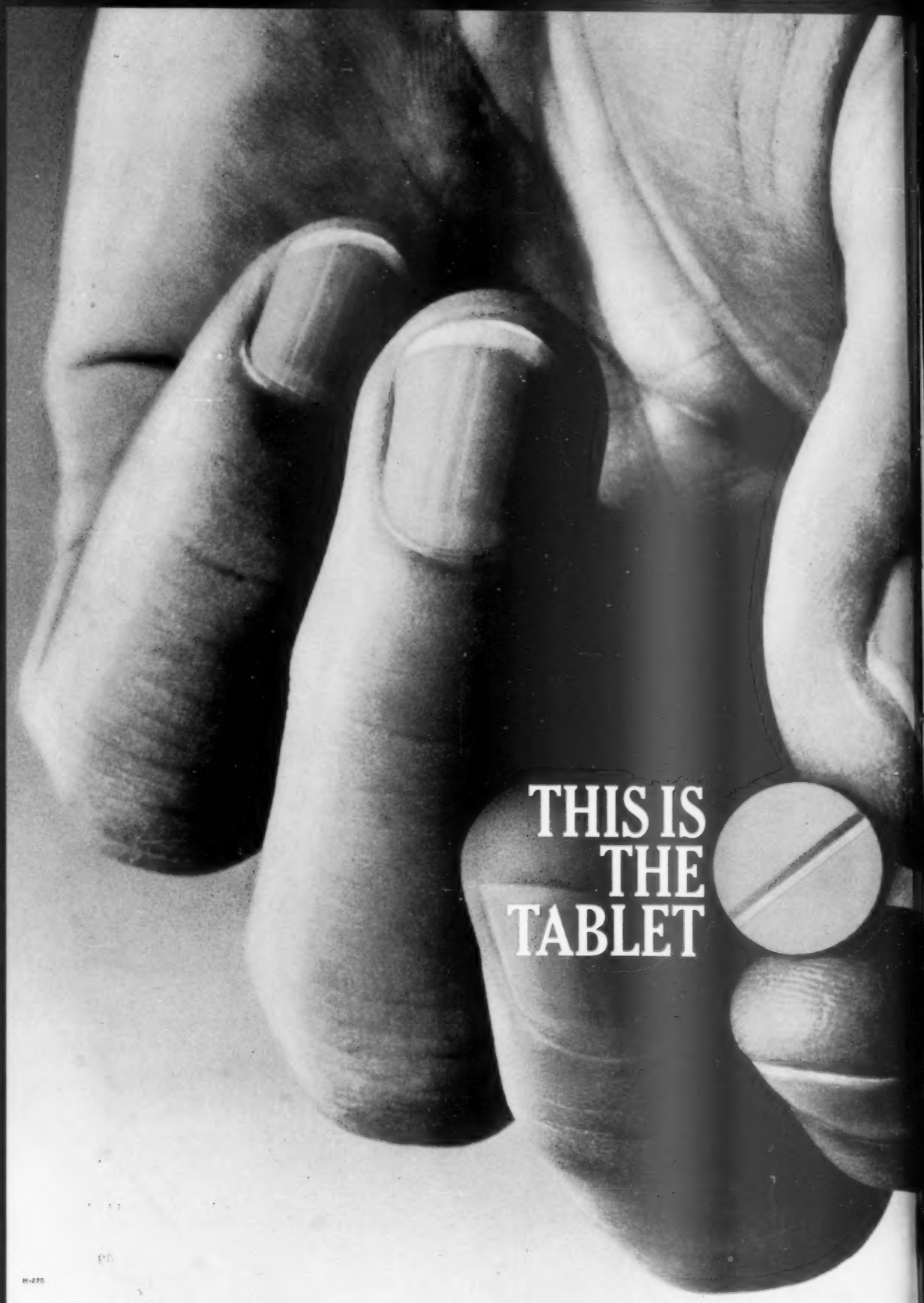
A limited number of rooms are available at the Diplomat Hotel for those members desiring to stay at the tournament site for the duration of the A.M.A. meeting. Reservation cards will be sent along with the tournament information.

The Diplomat is only a short ride from Miami Beach, just to the north.

A.A.G.P. Summer Clinics

The New Mexico Chapter of the Academy of General Practice will hold its Summer Clinics July 18-21 in the Nob Hill Auditorium in Ruidoso, New Mexico. The clinics will consist of morning sessions only, dealing with heart disease, mother and child, cancer and emergencies. Afternoons will be devoted to planned family activities.

Preregistration is handled by Randall W. Briggs, M.D., 406 N. Pennsylvania, Roswell, New Mexico. The fee for preregistration is $20.00 and regular registration is $25.00. Accommodations may be arranged through Bran Vanderstock, M.D., P.O. Box 116, Ruidoso, New Mexico.


THIS IS
THE
TABLET

ALSO VALUABLE IN THE PREOPERATIVE SUPPRESSION OF INTESTINAL FLORA,[2] AND IN THE ADJUNCTIVE MANAGEMENT OF HEPATIC COMA [9-11]

ADMINISTRATION AND DOSAGE

(expressed in terms of base)

Condition	Dosage (daily, in divided doses)	Duration of Therapy
Infectious Diarrheas (bacillary and nonspecific)	*Adults:* 35 to 50 mg/Kg; up to 100 mg/Kg in severe cases.	Up to 7 days
	Children: 50 mg/Kg; up to 100 mg/Kg in severe cases.	Up to 7 days
Intestinal Amebiasis (acute, subacute, chronic)	*Adults:* 0.75 to 1.5 Gm.; larger doses when required.	5 days
	Children: 22 mg/Kg; larger doses when required.	5 days
Preoperative Suppression of Intestinal Flora	*Adults:* 2 Gm.	4 days
Hepatic Coma	*Adults:* up to 6 Gm., depending on degree of hepatic insufficiency and response of patient.	See literature

SIDE EFFECTS: Since HUMATIN by the oral route is virtually nonabsorbed in the gastrointestinal tract, even with exceptionally high doses, systemic toxicity has not been a problem in clinical use.[2,3,5-8] However, when doses in excess of 2 Gm. per day are given for more than three days, loose stools may develop; on doses of from 4 to 6 Gm. daily, moderately severe diarrhea has been reported in some patients. No other indications of toxicity have been observed.

SUPPLIED: HUMATIN (paromomycin, Parke-Davis) is available as the sulfate in Kapseals,® each containing 250 mg. of base, in bottles of 16. Literature supplying details of dosage and administration available on request.

REFERENCES: (1) Coffey, G. L., *et al.*: *Antibiotics & Chemother.* 9:730, 1959. (2) Personal Communications to the Department of Clinical Investigation, Parke, Davis & Company, 1959. (3) Godenne, G. D.: Paromomycin in diarrheas of infants and children, Antibiotics Annual 1959-1960, New York, Medical Encyclopedia Inc., in press. (4) McMath, W. F. T., & Hussain, K. K.: *Pub. Health* 73:328, 1959. (5) Courtney, K. O., & Thompson, P. E.: Paromomycin as a therapeutic substance for intestinal amebiasis and bacterial enteritis, Antibiotics Annual 1959-1960, New York, Medical Encyclopedia Inc., in press. (6) Shafei, A. Z.: *Antibiotic Med. & Clin. Therapy* 6:275, 1959. (7) Elias, F. L., & Oliver-Gonzales, J.: *Antibiotic Med. & Clin. Therapy* 6:584, 1959. (8) Carter, C. H.: *Antibiotic Med. & Clin. Therapy* 6:586, 1959. (9) Fast, B. B., *et al.*: *Arch. Int. Med.* 101:467, 1958. (10) Mackie, J. E., *et al.*: *New England J. Med.* 259:1151, 1958. (11) Stormont, J. M., *et al.*: *New England J. Med.* 259:1145, 1958.

91740

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN PARKE-DAVIS

KAPSEALS®

humatin®

(PAROMOMYCIN, PARKE-DAVIS)